DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

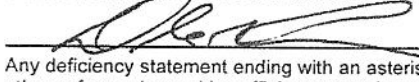
PRINTED: 10/26/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445296	A. BUILDING _____ B. WING _____	C 10/18/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF EAST RIDGE	1500 FINCHER AVENUE EAST RIDGE, TN 37412

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS AMENDED: October 26, 2011 Complaint investigation #28003, #28681, and #28690 were completed at Life Care Center of East Ridge on October 10, 2011, through October 18, 2011, with an extended survey completed on October 18, 2011. No deficiencies were cited for Complaint #28003 and #28681. Deficiencies were cited for Complaint #28690. Based on investigation of Complaint #28690, the facility was cited Immediate Jeopardy. The Administrator, Director of Nursing, and Regional Clinical Consultant were notified of the Immediate Jeopardy on October 18, 2011, at 11:45 a.m., in the conference room. The Immediate Jeopardy F-309 and F-333 cited at a "J" level constitues Substandard Quality of Care effective August 13, 2011, and is ongoing.	F 000	This allegation of compliance is submitted and required under Federal and State regulations and statutes applicable to long term care providers. The plan of correction does not constitute an admission of liability on the part of the facility and such liability is hereby specifically denied. The submission of this plan of correction does not constitute agreement by the facility that the surveyor's findings or conclusions are accurate, that the findings constitute a deficiency, or that the scope or severity regarding any of the deficiencies cited is correctly applied.	
F 157 SS=J	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of	F 157	F 157 SPECIFIC RESIDENTS Resident #8's care plan was updated 10-25-11 to include interventions of monitoring for adverse effects of Coumadin such as bleeding. On 8-21-11, Resident #8 had a 6.9 Prothrombin and International Normalization (PT/INR). The physician was notified of the change in condition, and an order was received for 10 mg of Vitamin K. 10 mg of Vitamin K was administered by the Licensed Nurse. Resident was transferred on 8-21-11 to Emergency	10/26/11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE



EL

11/1/11

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 157	Continued From page 1 treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on medical record review, review of facility records, review of medication publications, and interview, the facility failed to notify the physician of a change in condition, with bleeding gums, for one resident (#8) on Coumadin, Lovenox, and Plavix (blood thinning medications) of twenty-one residents reviewed. The facility's failure to notify the physician of a change in condition resulted in active bleeding in the mouth and a transfer to the hospital emergency room for evaluation for one resident (#8) of twenty-one residents reviewed placing resident #8 in Immediate Jeopardy (situation in which a provider's noncompliance with one or more requirements of participation has caused, or is likely to cause serious injury, harm, impairment or death). A meeting was held on October 18, 2011, at	F 157	Room where a PT/INR test was completed with an INR result of 2.8. The resident's PT/INR result continues to be monitored as ordered. The licensed nurse was re-educated by the Director of Nursing (DON) and Assistant Director of Nursing (ADON) on 10-21-11 regarding physician notification of change of condition. Licensed nurses' re-education was conducted from 10-22-11 through 10-26-11by the DON including (but not limited to) monitoring for adverse effects such as signs and symptoms of bleeding, notifying the physician with change of condition immediately, and care planning interventions related to adverse effects of Coumadin such as bleeding. One licensed nurse was not educated due to FMLA leave, and that nurse will not be allowed to work until they have been re-educated. Newly hired licensed nurses will be educated in orientation on adverse effects of Coumadin such as signs and symptoms of bleeding, the immediate notification of the physician with change of condition and care planning interventions for adverse effects of Coumadin such as bleeding.	

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F 157	Continued From page 2 11:45 a.m., in the Conference Room, with the Administrator, Director of Nursing, and Regional Director of Clinical Services to inform the facility of the Immediate Jeopardy. The Immediate Jeopardy was effective August 13, 2011, and is ongoing and Substandard Quality of Care. The findings included: Resident #8 was admitted to the facility on August 12, 2011, with diagnoses including Atrial Fibrillation, Hypertension, Late-Effects Hemiplegia (paralysis affecting only one side of the body), and Neuralgia. Medical record review of the admission orders dated August 12, 2011, revealed "...Coumadin 5 mg (milligrams) daily...PT/INR daily until INR is greater than or equal to 2.0..." Medical record review of the Interim (Admission) Care Plan (no date) revealed "...Resident Need: Potential for Bleeding...Related To: Coumadin..." Continued review of the Interventions section of the care plan revealed no interventions were identified (no interventions were selected on the care plan or written in the available spaces). Continued review revealed no interventions for bleeding or bleeding precautions. Review of the 300 Hall 24-Hour Report dated August 13, 2011, revealed "...PT/INR 37.9/3.2...No change..." Medical record review of a Nurse's Note dated August 13, 2011, at 1:50 p.m., revealed "...Pt (patient) gums bleeding upon inspection of the caries in mouth..." Continued review revealed no	F 157	OTHER RESIDENTS Residents on Coumadin have the potential to be affected. Residents receiving Coumadin therapy were reviewed by the DON, nurse practitioner (NP) and nurse managers on 10-13-11 for PT/INR monitoring , the Coumadin order, and the MAR for accuracy. On 10-26-11 residents on Coumadin were assessed for adverse effects such as signs and symptoms of bleeding and/or bruising by LPNs, RNs and Unit Managers. The clinical meeting will review the 24-hour report for the following: changes of condition from the 24-hour report, notification of MD/NP from nursing documentation and physician orders, order implementation from nursing documentation, Responsible Party notification from nursing documentation, care plans updated and reviewed, and nursing documentation both electronic and written. The 24-hour report meeting will also discuss residents that were sent to hospital during the previous 24-hours. The	

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F 157	Continued From page 3 documentation the Physician or Nurse Practitioner (NP) was notified of the bleeding gums. Medical record review of the PT/INR/Coumadin Flowsheet revealed "...August 15, 2011...PT 60.2; INR 5.0...Current Dose (Coumadin) 5 mg...Dose Change: Hold..." Medical record review of a Physician's Telephone Order dated August 15, 2011, at 6:00 p.m., revealed "...Vit (vitamin) K (used to reverse the anticoagulation effect of Coumadin) 10 mg po (by mouth) now. DC (discontinue) Lovenox (a blood thinning medication) 40 mg Subq (subcutaneous) daily. DC Plavix (a medication that destroys or inhibits platelet function) 75 mg po daily. Check PT/INR in AM (morning). Hold Coumadin today..." Medical record review of the PT/INR/Coumadin Flowsheet revealed "...August 19, 2011...PT 56.7; INR 4.7...Current Dose (Coumadin) 5 mg...Dose Change: Hold..." Medical record review of a Physician's Telephone Order dated August 19, 2011, at 1:20 p.m., revealed "...Hold all Coumadin for today. Next PT/INR on August 20, 2011..." Medical record review of the PT/INR Flowsheets, Medication Administration Records (MARs), Treatment Administration Records (TARs), Nurse's Notes and review of the facility's 24-Hour Report revealed no documentation the PT/INR was completed on August 20, 2011. Medical record review of the PT/INR/Coumadin Flowsheet revealed "...August 21, 2011...PT 83.3/ INR 6.9...Current Dose (Coumadin) 5 mg...Dose	F 157	weekday meeting will be attended by the DON, ADON,and Unit Managers. Weekend and Holiday review will be conducted by the Weekend Supervisor. This process was initiated by DON on 9-6-11 and it was reviewed with the ADON, Unit Managers and Weekend Supervisor, at that time by demonstration.	

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F 157	Continued From page 4	F 157		

Change: Hold..." Medical record review of a Physician's Telephone Order dated August 21, 2011, at 12:30 p.m., revealed "...Give Vit K 10 mg po now. Recheck PT/INR on August 22, 2011..."

Medical record review of a Nurse's Note dated August 21, 2011, at 10:40 p.m., revealed "...Sent patient out to ER (Emergency Room). Noticed patient having dried blood around (resident's) lips. When (resident) opened mouth there was blood all in it. Patient was complaining of stomach pain. A.M. PT and INR was 83.3 and 6.9 gave Vitamin K 10 then held p.m. dose of Coumadin. Rechecked when blood was noticed, 46.5 and 3.9. Notified (name) of all the above (NP) requested to send (resident) out..."

Medical record review of the Hospital Emergency Department Record dated August 21, 2011, at 10:15 p.m. (disposition time), revealed the resident was seen in the Emergency Room due to abnormal labs at the Nursing Home. Continued review revealed a diagnostic study to check for blood in the resident's stool and urine was completed and was positive. Further review revealed the resident was released from the Emergency Room to return to the facility on August 21, 2011, at 11:50 p.m.

Review of the website fda.gov (United States Food and Drug Administration) for the Medication Guide, Coumadin, revealed "What is the most important information I should know about COUMADIN? COUMADIN is very important for your health, but it can cause serious and life-threatening bleeding problems. To benefit from COUMADIN and also lower your chance for bleeding problems, you must: Call your

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F 157	Continued From page 5 healthcare provider right away if you get any of the following signs or symptoms of bleeding problems:...bleeding gums..." Interview with Licensed Practical Nurse (LPN) #1, by telephone, on October 17, 2011, at 2:30 p.m., confirmed the Physician or Nurse Practitioner (NP) was not notified of the resident's bleeding gums on August 13, 2011. LPN #1 stated, "There was dried blood in the corners of (resident's) mouth. I looked inside and the gums were bleeding. I cleaned (resident) up, then I noticed fresh blood in (resident's) mouth. I looked and checked for sores and loose teeth, but there were none. I went to the chart after cleaning (resident's) mouth and saw all of the blood thinners and realized the bleeding had nothing to do with loose teeth. Then it clicked, it was the blood thinners. I just didn't think to call the doctor or report it to anyone; I'm a new nurse and I try to dot my "I"s and cross my "T"s, but I miss things sometimes." Interview with the Director of Nursing (DON) on October 17, 2011, at 2:45 p.m., in the Conference Room, confirmed the facility failed to notify the Physician or Nurse Practitioner of the resident's bleeding gums on August 13, 2011. Continued interview confirmed the DON was unaware the resident's gums were bleeding on August 13, 2011. Continued interview confirmed the facility failed to train and educate staff on bleeding precautions or interventions. Continued interview confirmed the facility failed to obtain the PT/INR on August 20, 2011, for the resident on Anticoagulation Therapy. Further interview confirmed the DON was unaware the resident required administration of Vitamin K due to an	F 157		

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F 157	Continued From page 6 elevated PT/INR and was sent to the Emergency Room for an elevated PT/INR and bleeding around the mouth on August 21, 2011. The DON stated, "The communication is poor." Interview with the Administrator on October 18, 2011, at 2:00 p.m., in the Conference Room, confirmed the Administrator was unaware the resident's gums were bleeding on August 13, 2011. Continued interview confirmed the facility failed to obtain the PT/INR on August 20, 2011, for the resident on Coumadin Therapy. Continued interview confirmed the facility failed to train and educate staff on bleeding precautions or interventions. Continued interview confirmed the Administrator was unaware the resident required administration of Vitamin K due to an elevated PT/INR and was sent to the Emergency Room for an elevated PT/INR and bleeding around the mouth on August 21, 2011. C/O #28690	F 157		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on medical record review, review of facility records, review of medication publications, and interview, the facility failed to develop a care plan with interventions for bleeding precautions for one resident (#8) on Coumadin, Lovenox, and Plavix (blood thinning medications) of twenty-one residents reviewed.	F 281		

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F 281	Continued From page 7 The findings included: Resident #8 was admitted to the facility on August 12, 2011, with diagnoses including Atrial Fibrillation, Hypertension, Late-Effects Hemiplegia (paralysis affecting only one side of the body), and Neuralgia. Medical record review of the admission orders dated August 12, 2011, revealed "...Coumadin 5 mg (milligrams) daily...PT/INR daily until INR is greater than or equal to 2.0..." Medical record review of the Interim (Admission) Care Plan (no date) revealed "...Resident Need: Potential for Bleeding...Related To: Coumadin..." Continued review of the Interventions section of the care plan revealed no interventions were identified (no interventions were selected on the care plan or written in the available spaces). Continued review revealed no interventions for bleeding or bleeding precautions. Review of the 300 Hall 24-Hour Report dated August 13, 2011, revealed "...PT/INR 37.9/3.2...No change..." Medical record review of a Nurse's Note dated August 13, 2011, at 1:50 p.m., revealed "...Pt (patient) gums bleeding upon inspection of the caries in mouth..." Continued review revealed no documentation the Physician or Nurse Practitioner (NP) was notified of the bleeding gums. Medical record review of the PT/INR/Coumadin Flowsheet revealed "...August 15, 2011...PT 60.2;	F 281		

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F 281	Continued From page 8 INR 5.0...Current Dose (Coumadin) 5 mg...Dose Change: Hold..." Medical record review of a Physician's Telephone Order dated August 15, 2011, at 6:00 p.m., revealed "...Vit (vitamin) K (used to reverse the anticoagulation effect of Coumadin) 10 mg po (by mouth) now. DC (discontinue) Lovenox (a blood thinning medication) 40 mg Subq (subcutaneous) daily. DC Plavix (a medication that destroys or inhibits platelet function) 75 mg po daily. Check PT/INR in AM (morning). Hold Coumadin today..." Medical record review of the PT/INR/Coumadin Flowsheet revealed "...August 19, 2011...PT 56.7; INR 4.7...Current Dose (Coumadin) 5 mg...Dose Change: Hold..." Medical record review of a Physician's Telephone Order dated August 19, 2011, at 1:20 p.m., revealed "...Hold all Coumadin for today. Next PT/INR on August 20, 2011..." Medical record review of the PT/INR Flowsheets, Medication Administration Records (MARs), Treatment Administration Records (TARs), Nurse's Notes and review of the facility's 24-Hour Report revealed no documentation the PT/INR was completed on August 20, 2011. Medical record review of the PT/INR/Coumadin Flowsheet revealed "...August 21, 2011...PT 83.3/ INR 6.9...Current Dose (Coumadin) 5 mg...Dose Change: Hold..." Medical record review of a Physician's Telephone Order dated August 21, 2011, at 12:30 p.m., revealed "...Give Vit K 10 mg po now. Recheck PT/INR on August 22, 2011..." Medical record review of a Nurse's Note dated	F 281		

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F 281	Continued From page 9 August 21, 2011, at 10:40 p.m., revealed "...Sent patient out to ER (Emergency Room). Noticed patient having dried blood around (resident's) lips. When (resident) opened mouth there was blood all in it. Patient was complaining of stomach pain. A.M. PT and INR was 83.3 and 6.9 gave Vitamin K 10 then held p.m. dose of Coumadin. Rechecked when blood was noticed, 46.5 and 3.9. Notified (name) of all the above (NP) requested to send (resident) out..." Medical record review of the Hospital Emergency Department Record dated August 21, 2011, at 10:15 p.m. (disposition time), revealed the resident was seen in the Emergency Room due to abnormal labs at the Nursing Home. Continued review revealed a diagnostic study to check for blood in the resident's stool and urine was completed and was positive. Further review revealed the resident was released from the Emergency Room to return to the facility on August 21, 2011, at 11:50 p.m. Review of the website fda.gov (United States Food and Drug Administration) for the Medication Guide, Coumadin, revealed, "What is the most important information I should know about COUMADIN? COUMADIN is very important for your health, but it can cause serious and life-threatening bleeding problems. To benefit from COUMAIN and also lower your chance for bleeding problems, you must: Call your healthcare provider right away if you get any of the following signs or symptoms of bleeding problems:...bleeding gums..." Interview with Licensed Practical Nurse (LPN) #1, by telephone, on October 17, 2011, at 2:30 p.m.,	F 281		

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F 281	Continued From page 10	F 281		

confirmed the Physician or Nurse Practitioner (NP) was not notified of the resident's bleeding gums on August 13, 2011. LPN #1 stated, "There was dried blood in the corners of (resident's) mouth. I looked inside and the gums were bleeding. I cleaned (resident) up, then I noticed fresh blood in (resident's) mouth. I looked and checked for sores and loose teeth, but there were none. I went to the chart after cleaning (resident's) mouth and saw all of the blood thinners and realized the bleeding had nothing to do with loose teeth. Then it clicked, it was the blood thinners. I just didn't think to call the doctor or report it to anyone; I'm a new nurse and I try to dot my "I"s and cross my "T"s, but I miss things sometimes."

Interview with the Director of Nursing (DON) on October 17, 2011, at 2:45 p.m., in the Conference Room, confirmed the facility failed to notify the Physician or Nurse Practitioner of the resident's bleeding gums on August 13, 2011. Continued interview confirmed the DON was unaware the resident's gums were bleeding on August 13, 2011. Continued interview confirmed the facility failed to train and educate staff on bleeding precautions or interventions. Continued interview confirmed the facility failed to obtain the PT/INR on August 20, 2011, for the resident on Anticoagulation Therapy. Further interview confirmed the DON was unaware the resident required administration of Vitamin K due to an elevated PT/INR and was sent to the Emergency Room for an elevated PT/INR and bleeding around the mouth on August 21, 2011. The DON stated, "The communication is poor."

Interview with the Administrator on October 18,

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F 281	Continued From page 11 2011, at 2:00 p.m., in the Conference Room, confirmed the facility failed to obtain the PT/INR on August 20, 2011, for the resident on Coumadin Therapy. Continued interview confirmed the Administrator was unaware the resident's gums were bleeding on August 13, 2011. Continued interview confirmed the facility failed to train and educate staff on bleeding precautions or interventions. Continued interview confirmed the Administrator was unaware the resident required administration of Vitamin K due to an elevated PT/INR and was sent to the Emergency Room for an elevated PT/INR and bleeding around the mouth on August 21, 2011. Refer to F-157 (J)			
F 309 SS=J	C/O #28690 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on medical record review, review of facility records, review of medication publications, and interview, the facility failed to develop a care plan with interventions for bleeding precautions and failed to educate staff on bleeding precautions for one resident (#8); failed to notify the physician of	F 309	F 309 SPECIFIC RESIDENTS Resident #8's care plan was updated 8/25/11 to include interventions for adverse effects of Coumadin such as bleeding. On 8-21-11, Resident #8 had a 6.9 Prothrombin and International Normalization (PT/INR). The physician was notified of the change in condition, and an order was received for 10 mg of Vitamin K. 10 mg of Vitamin K was administered by the Licensed Nurse. Resident was transferred on 8-21-11 to Emergency Room where a PT/INR test was completed with an INR result of 2.8. The resident's PT/INR result continues to be monitored as ordered. The licensed nurse was re-educated by the Director of Nursing (DON) and Assistant Director of Nursing (ADON) on 10-21-11 on physician notification of change of condition. Resident #4's medical record was reviewed on 10-13-11 by the DON to ensure the resident was receiving the correct dosage of Coumadin as ordered by the physician. The licensed nurse was re-educated by the Director of Nursing (DON) and Assistant Director of Nursing (ADON) on 10-14-11 on accurate transcription, specifically the clarification of handwritten orders, notification of DON/MD on all	10/26/11

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F 309	Continued From page 12 a change in condition for one resident (#8); failed to monitor the Protime/International Normalization Ratio (PT/INR-lab test used to determine therapeutic levels for blood thinning medications) as ordered by the physician for one resident (#8); failed to administer the correct dosage of Coumadin (a blood thinning medication) for one resident (#4); and failed to administer Coumadin as ordered by the physician for one resident (#9) of twenty-one residents reviewed. The facility's failure to develop a care plan with interventions, failure to educate staff on bleeding precautions, failure to notify the physician of a change in condition, and failure to monitor the blood thinner levels as ordered by the physician resulted in active bleeding in the mouth and a transfer to the hospital emergency room for evaluation for one resident (#8); failure to administer the correct dosage of Coumadin as ordered by the physician for one resident (#4); and failure to administer Coumadin as ordered by the physician for one resident (#9) of twenty-one residents reviewed placed resident #8, #4, #9 in Immediate Jeopardy (situation in which a provider's noncompliance with one or more requirements of participation has caused, or is likely to cause serious injury, harm, impairment or death). A meeting was held on October 18, 2011, at 11:45 a.m., in the Conference Room, with the Administrator, Director of Nursing, and Regional Director of Clinical Services to inform the facility of the Immediate Jeopardy. The Immediate Jeopardy consititues Substandard Quality of Care effective August 13, 2011, and is ongoing. The findings included:	F 309	Coumadin orders of 6mg and greater, and the verification of all orders as they relate to hospital records and transfer orders. Resident #9's medical record was reviewed by the DON on 10-13-11to ensure the resident was receiving Coumadin as ordered by the physician. The licensed nurses were re-educated on 10-14-11 by DON and ADON on medication administration, specifically the following of physician orders, and the double-checking of admission orders and Medication Administration Review (MAR) reports. OTHER RESIDENTS Residents on Coumadin have the potential to be affected. Residents receiving Coumadin therapy were reviewed by the DON, NP and nurse managers on 10-13-11 for PT/INR monitoring , the Coumadin order, and the MAR for accuracy. On 10-26-11 residents on Coumadin were assessed for monitoring for adverse effects such as signs and symptoms of bleeding and/or bruising by LPNs, RNs and Unit Managers. Care plans were updated by nurse managers on 10-25-11 for interventions for bleeding precautions. Residents on Coumadin therapy are reviewed daily by Nursing	

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F 309	Continued From page 13 Resident #8 was admitted to the facility on August 12, 2011, with diagnoses including Atrial Fibrillation, Hypertension, Late-Effects Hemiplegia (paralysis affecting only one side of the body), and Neuralgia. Medical record review of the admission orders dated August 12, 2011, revealed "...Coumadin 5 mg (milligrams) daily...PT/INR daily until INR is greater than or equal to 2.0..." Medical record review of the Interim (Admission) Care Plan (no date) revealed "...Resident Need: Potential for Bleeding...Related To: Coumadin..." Continued review of the Interventions section of the care plan revealed no interventions were identified (no interventions were selected on the care plan or written in the available spaces). Continued review revealed no interventions for bleeding or bleeding precautions. Review of the 300 Hall 24-Hour Report dated August 13, 2011, revealed "...PT/INR 37.9/3.2...No change..." Medical record review of a Nurse's Note dated August 13, 2011, at 1:50 p.m., revealed "...Pt (patient) gums bleeding upon inspection of the caries in mouth..." Continued review revealed no documentation the Physician or Nurse Practitioner (NP) was notified of the bleeding gums. Medical record review of the PT/INR/Coumadin Flowsheet revealed "...August 15, 2011...PT 60.2; INR 5.0...Current Dose (Coumadin) 5 mg...Dose Change: Hold..."	F 309	Administration (Director of Nursing, Assistant Director of Nursing, Weekend Supervisor and Unit Managers) to ensure the PT/INR test has been completed as ordered by the physician. The MAR is reviewed daily by Nursing Administration (Director of Nursing, Assistant Director of Nursing, Weekend Supervisor and Unit Managers) to ensure Coumadin had been given that day and had been documented appropriately. New physician orders are reviewed daily by Nursing Administration (Director of Nursing, Assistant Director of Nursing, Weekend Supervisor and Unit Managers) to ensure accuracy in transcription on the MAR. The medication sent from pharmacy will be checked daily by the unit managers and the licensed nurses to ensure the correct dose is on hand. Newly admitted residents (see Coumadin meeting process started 10-13-11for current residents) receiving Coumadin will have Coumadin orders verified for accuracy from transferring facility prior to admission by admission nurses. The orders will be compared to the original transferring records. If the Coumadin dose is higher or equal to 6 milligrams, the DON will be notified for further investigation by verifying with the physician orders or contacting the admitting physician. The admission nurses/licensed nurses will	

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F 309	Continued From page 14 Medical record review of a Physician's Telephone Order dated August 15, 2011, at 6:00 p.m., revealed "...Vit (vitamin) K (used to reverse the anticoagulation effect of Coumadin) 10 mg po (by mouth) now. DC (discontinue) Lovenox (a blood thinning medication) 40 mg Subq (subcutaneous) daily. DC Plavix (a medication that destroys or inhibits platelet function) 75 mg po daily. Check PT/INR in AM (morning). Hold Coumadin today..." Medical record review of the PT/INR/Coumadin Flowsheet revealed "...August 19, 2011...PT 56.7; INR 4.7...Current Dose (Coumadin) 5 mg...Dose Change: Hold..." Medical record review of a Physician's Telephone Order dated August 19, 2011, at 1:20 p.m., revealed "...Hold all Coumadin for today. Next PT/INR on August 20, 2011..." Medical record review of the PT/INR Flowsheets, Medication Administration Records (MARs), Treatment Administration Records (TARs), Nurse's Notes and review of the facility's 24-Hour Report revealed no documentation the PT/INR was completed on August 20, 2011. Medical record review of the PT/INR/Coumadin Flowsheet revealed "...August 21, 2011...PT 83.3/ INR 6.9...Current Dose (Coumadin) 5 mg...Dose Change: Hold..." Medical record review of a Physician's Telephone Order dated August 21, 2011, at 12:30 p.m., revealed "...Give Vit K 10 mg po now. Recheck PT/INR on August 22, 2011..." Medical record review of a Nurse's Note dated August 21, 2011, at 10:40 p.m., revealed "...Sent patient out to ER (Emergency Room). Noticed patient having dried blood around (resident's) lips.	F 309	verify Coumadin orders with the admitting physician on day of admission. Licensed nurses were educated on this process by the SDC (Staff Development Coordinator) and DON from 10-22-11 through 10-26-11. The Regional Director of Clinical Services (RDCS) inserviced DON and Nursing Administration (Assistant Director of Nursing, and Unit Managers and Weekend Supervisor) on 10-12-11 on Coumadin protocols and procedures. These included the following: Bringing charts, MARs and Coumadin flow records to the Coumadin meeting. Checking residents' orders for Coumadin against MAR and flow sheet. Checking MARs for correct transcriptions and any omissions on MAR for administering medications. Checking for PT/INRs being done as ordered and notification to MD of PT/INR. Orders written on telephone orders and updating MARs. Checking for any antibiotic use. Checking care plans for antibiotic use interactions with other medications. From 10-14-11 through 10-20-11, an in-service education of licensed nursing staff was completed by the SDC (Staff Development Coordinator) regarding accurate transcription, verification of medication doses, administration of medication according to physician	

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F 309	Continued From page 15 When (resident) opened mouth there was blood all in it. Patient was complaining of stomach pain. A.M. PT and INR was 83.3 and 6.9 gave Vitamin K 10 then held p.m. dose of Coumadin. Rechecked when blood was noticed, 46.5 and 3.9. Notified (name) of all the above (NP) requested to send (resident) out..." Medical record review of the Hospital Emergency Department Record dated August 21, 2011, at 10:15 p.m. (disposition time), revealed the resident was seen in the Emergency Room due to abnormal labs at the Nursing Home. Continued review revealed a diagnostic study to check for blood in the resident's stool and urine was completed and was positive. Further review revealed the resident was released from the Emergency Room to return to the facility on August 21, 2011, at 11:50 p.m. Review of the website fda.gov (United States Food and Drug Administration) for the Medication Guide, Coumadin, revealed, "What is the most important information I should know about COUMADIN? COUMADIN is very important for your health, but it can cause serious and life-threatening bleeding problems. To benefit from COUMAIN and also lower your chance for bleeding problems, you must: Call your healthcare provider right away if you get any of the following signs or symptoms of bleeding problems:...bleeding gums..." Interview with Licensed Practical Nurse (LPN) #1, by telephone, on October 17, 2011, at 2:30 p.m., confirmed the Physician or Nurse Practitioner (NP) was not notified of the resident's bleeding gums on August 13, 2011. LPN #1 stated,	F 309	orders, and obtaining lab results as ordered. Licensed nurses' re-education was conducted from 10-22-11 through 10-26-11by the DON including (but not limited to: monitoring for adverse effects such as signs and symptoms of bleeding, notifying the physician with change of condition immediately, care planning interventions related to adverse effects of Coumadin such as bleeding, accurate transcription, verification of medication doses, administration of medication according to physician orders, and obtaining lab results as ordered. One licensed nurse was not educated due to FMLA leave, and that nurse will not be allowed to work until they have been re-educated. Newly hired licensed nurses will be educated in orientation on adverse effects of Coumadin such as signs and symptoms of bleeding, the immediate notification of the physician with change of condition, and care planning interventions for adverse effects of Coumadin such as bleeding. Nursing Administration (Director of Nursing, Assistant Director of Nursing & Unit Managers on weekdays, and Weekend Supervisor on weekends and holidays) is monitoring PT/INR results daily.	

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F 309	Continued From page 16 "There was dried blood in the corners of (resident's) mouth. I looked inside and the gums were bleeding. I cleaned (resident) up, then I noticed fresh blood in (resident's) mouth. I looked and checked for sores and loose teeth, but there were none. I went to the chart after cleaning (resident's) mouth and saw all of the blood thinners and realized the bleeding had nothing to do with loose teeth. Then it clicked, it was the blood thinners. I just didn't think to call the doctor or report it to anyone; I'm a new nurse and I try to dot my "I"s and cross my "T"s, but I miss things sometimes." Interview with the Director of Nursing (DON) on October 17, 2011, at 2:45 p.m., in the Conference Room, confirmed the facility failed to notify the Physician or Nurse Practitioner of the resident's bleeding gums on August 13, 2011. Continued interview confirmed the facility failed to train and educate staff on bleeding precautions or interventions. Continued interview confirmed the facility failed to obtain the PT/INR on August 20, 2011, for the resident on Anticoagulation Therapy. Further interview confirmed the DON was unaware the resident required administration of Vitamin K due to an elevated PT/INR and was sent to the Emergency Room for an elevated PT/INR and bleeding around the mouth on August 21, 2011. The DON stated, "The communication is poor." Interview with the Administrator on October 18, 2011, at 2:00 p.m., in the Conference Room, confirmed the facility failed to obtain the PT/INR on August 20, 2011, for the resident on Coumadin Therapy. Continued interview confirmed the facility failed to train and educate	F 309	As of 10-13-11, this new Coumadin process involves the following: PT/INRs to be drawn in the morning by the licensed nurse assigned to the resident. The licensed nurse assigned to the resident records the results on the PT/INR flow sheet and signs the flow sheet. The licensed nurse assigned to the resident records the results on the MAR and initials that it is completed. As of 10/13/11, Nursing Administration and the Nurse Practitioner conduct a weekday Coumadin meeting, which consists of the following: A) Review of all PT/INR results and write any new orders for Coumadin including the next scheduled PT/INR. If any Coumadin order is greater than 6mg, the DON will be notified. B) Unit Managers will compare pink anticoagulation MARs and PT/INR flow sheets with all current Coumadin orders to ensure the order is transcribed accurately to both MAR and PT/INR flow sheet. C) Orders on newly admitted residents receiving Coumadin will as of 10/13/11 be reviewed for accuracy by the Unit Managers in the Coumadin Meeting. The Coumadin orders will be compared to the original hospital orders, and if any Coumadin order is greater than 6mg, the DON will be notified (All licensed nurses were educated 10-22-11 through 10-26-11by the DON regarding this protocol)	

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F 309	Continued From page 17 staff on bleeding precautions or interventions. Continued interview confirmed the Administrator was unaware the resident required administration of Vitamin K due to an elevated PT/INR and was sent to the Emergency Room for an elevated PT/INR and bleeding around the mouth on August 21, 2011. Resident #4 was admitted to the facility on September 7, 2011, with diagnoses including Hip Joint Replacement, Severe Degenerative Joint Disease, and Transient Ischemic Attacks (a brief interruption of the blood supply to part of the brain and may be a warning sign for a full-scale stroke). Medical record review of the Physician Recapitulation Orders from the transferring facility dated September 4, 2011 through September 30, 2011, revealed "...Coumadin 2.5 mg po daily (hand-written)..." Medical record review of a Nurse's Note from the transferring facility dated September 4, 2011, at 11:17 p.m., revealed "...admitted from (hospital) with total left hip replacement from degeneration...resident on Coumadin 2.5 (milligrams). PT/INR to be checked in a.m..." Medical record review of a Nurse's Note from the transferring facility dated September 5, 2011, at 12:34 a.m., revealed "...PT/INR 46.6/3.9..." Medical record review of a Physician's Telephone Order from the transferring facility dated September 5, 2011, at 11:00 a.m., revealed "...Continue to hold Coumadin today...recheck PT/INR September 6, 2011..." Medical record review of the PT/INR/Coumadin	F 309	At the completion of the Coumadin meeting the unit manager will, as of 10/13/11, return the charts to the floor and notify the licensed nurse assigned to the resident of any orders. The licensed nurse assigned to the resident is to notify the pharmacy of any new Coumadin orders via fax. The Unit Managers are as of 10/13/11 to ensure the proper Coumadin dose is in the medication cart before the 5pm medication administration. On weekends and holidays, the Weekend Supervisor will, as of 10/13/11, collect the PT/INR flow sheet books to ensure that the PT/INRs were completed as ordered. The Weekend Supervisor will call the NP with the results of any new PT/INRs and write any new telephone orders needed The MARs will be checked to ensure that the Coumadin dose and order is transcribed accurately. The weekend supervisor will ensure that the proper Coumadin dose is in the medication cart before the 5pm medication administration. The Weekend Supervisor will be present at the Monday Coumadin meeting. The physician/NP is notified by nursing administration (Director of Nursing, Assistant Director of Nursing, Weekend Supervisor and Unit Managers) of all PT/INR results daily and gives new	

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F 309	Continued From page 18 Flowsheet from the transferring facility revealed "...September 6, 2011...PT 46.8; INR 3.9...Current Dose (Coumadin) 2.5 mg...Dose Change: Hold..." Medical record review of a Physician's Telephone Order from the transferring facility dated September 6, 2011, (time is illegible) revealed "...Continue to hold Coumadin...recheck PT/INR on September 8, 2011..." Medical record review of a Physician's Telephone Order from the transferring facility dated September 6, 2011, (no time) revealed "...Resident will transfer to (nursing home) on September 7, 2011, per family request...Continue all other physician orders..." Medical record review of the Admission Orders entered into the electronic charting system by LPN #2, dated September 7, 2011, revealed "...Coumadin 12.5 mg po daily (a hand-written line was struck through the "12.5 mg po daily" and was illegibly initialed)...PT/INR on September 8, 2011, and call NP with results prior to giving Coumadin...PT/INR every three days x (times) two weeks...PT/INR every Wednesday (start September 21, 2011)..." Medical record review of the PT/INR/Coumadin Flowsheet revealed "...September 8, 2011...PT 19.2; INR 1.6...Current Dose (Coumadin) 12.5 mg...Dose Change: (blank)..." Medical record review of the MAR dated September 2011, revealed "...PT/INR on September 8, 2011, and call NP with results prior to giving Coumadin..." was initialed as completed by LPN #3. Continued review revealed the resident was administered Coumadin 12.5 mg on September 8, 9, 10, 2011.	F 309	orders as needed for Coumadin along with the date of the next PT/INR. The MAR is reviewed daily by Nursing Administration (Director of Nursing, Assistant Director of Nursing, Weekend Supervisor and Unit Managers) to ensure the correct dose of Coumadin has been given and documented correctly. New physician orders are reviewed daily by the Nursing Administration (Director of Nursing, Assistant Director of Nursing, Weekend Supervisor and Unit Managers) to ensure the correct dose is written on the MAR. The medication sent from pharmacy was being checked by licensed nurses prior, a new process was put in place to expand this check to Unit Managers on 10-26-11.	

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F 309	Continued From page 19 Medical record review of the PT/INR/Coumadin Flowsheet revealed "...September 11, 2011...PT 96.0; INR 8.0...Current Dose (Coumadin) 12.5 mg...Dose Change: Hold Coumadin..." Medical record review of a Physician's Telephone Order dated September 11, 2011, at 2:00 p.m., revealed "...Vit K 10 mg PO x 1 (one) dose now...Recheck PT/INR stat (immediately).." Medical record review of a PT/INR obtained on September 11, 2011, at 3:11 p.m., revealed "...PT > (greater than) 120.0; INR >14.0 (Therapeutic Range: PT 10.2-13.6; INR 2.0-3.5)..." Medical record review of a PT/INR obtained on September 11, 2011, at 4:23 p.m., revealed "...PT 116.5; INR 13.6...Medical record review of a Physician's Telephone Order dated September 11, 2011, at 5:00 p.m., revealed "...Vit K 10 mg PO x 1 dose now...PT 116.5; INR 13.60...Recheck PT/INR 3 (three) hours after Vit K dose..." Medical record review of a Nurse's Note dated September 11, 2011, at 10:24 p.m., revealed "...at 8:00 p.m., PT 48.1; INR 4.0..." Medical record review of a Physician's Telephone Order dated September 11, 2011, at 9:00 p.m., revealed "...Hold Coumadin September 12, 2011...PT/ INR September 12, 2011..." Medical record review of the PT/INR/Coumadin Flowsheet revealed "...September 12, 2011...PT 18.1; INR 1.5...Current Dose (Coumadin) On Hold...Dose Change: Hold Coumadin..." Medical record review of a Physician's Telephone Order dated September 12, 2011, at 10:00 a.m., revealed "...Start Coumadin 2 mg PO daily...Start	F 309		

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F 309	Continued From page 20 September 13, 2011...Recheck PT/ INR September 13, 2011..." Review of a facility investigation, to include DON and Administrator investigative data review, dated September 14, 2011, and Medical Director dated October 1, 2011, revealed "...Summary of Investigative Facts: Orders from the transferring facility not clearly written for Coumadin orders. Coumadin was transcribed on physician's orders as a higher dose than ordered from the transferring facility. Coumadin was given after PT/INR was checked on September 8, 2011 as ordered from transferring facility which caused resident's PT/INR to be out of range. Vitamin K ordered on September 11, 2011, after PT/INR was ordered on that date. VSS (vital signs stable)... PT/INR out of range...NP notified...Vitamin K order... Coumadin held...PT/INR ordered...Once PT/INR was in range NP ordered correct dose to be given...Recommendations/Actions Taken: For future review if a Coumadin dose is over 10 mg, Nursing will clarify order with MD (Medical Doctor)/NP and notify DON..." Continued review revealed an attached Record of In-Service dated September 12, 2011. Continued review revealed two LPN signatures were on the In-Service Signature Sheet. Review of the facility's Current Associate (Employees) List dated October 18, 2011, revealed 68 licensed nurses employed by the facility. Interview with LPN #2 on October 11, 2011, at 11:40 a.m., in the Conference Room, confirmed the transferring facility's hand-written order for Coumadin 2.5 mg daily, was misread and	F 309		

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F 309	Continued From page 21 incorrectly transcribed into the facility's electronic charting system as Coumadin 12.5 mg daily. LPN #2 stated, "I thought the orders said 12.5 mg." Continued interview confirmed LPN #2 reviewed the transferring facility's previous physician orders to hold the Coumadin and to check and recheck PT/INRs. Continued interview confirmed "When Coumadin is held and PT/INRs are being rechecked, it is because the INRs are too high from the Coumadin, the resident is getting too much Coumadin." Continued interview confirmed the Coumadin being held and the PT/INRs rechecked on a newly admitted resident did not alert or alarm LPN #2. Further interview confirmed LPN #2 failed to verify the 12.5 mg dosage of Coumadin with the transferring facility and/or the physician upon admission. Interview with the Resident's Attending Physician (Medical Director) on October 11, 2011, at 1:30 p.m, by telephone, and on October 18, 2011, at 8:40 a.m., in the Conference Room, confirmed the Physician did review and sign the Admission Orders on September 9, 2011, and stated, "I signed the orders based on the understanding the Coumadin 12.5 mg daily was what the resident was receiving in the transferring facility and based on the understanding there was no transcription errors." Interview with LPN #3 on October 11, 2011, at 3:00 p.m., in the Conference Room, confirmed LPN #3 notified the NP of the PT/INR results (obtained in-house) on September 8, 2011, prior to giving Coumadin. Continued interview confirmed LPN #3 and Registered Nurse (RN) #1 reviewed the Admission Orders for accuracy, and	F 309		

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F 309	Continued From page 22	F 309		

stated "I reviewed the Admission Orders as RN #1 read the (transferring facility's) orders aloud; RN #1 read the Coumadin 2.5 mg daily as Coumadin 12.5 mg daily." LPN #3 stated "When RN #1 read the 12.5 mg, I thought, that's a lot of Coumadin, but didn't say anything. If I was going to be the one giving the 12.5 mg, I would have validated why (resident) was to get 12.5 mg, but at this point, I wasn't giving it."

Interview with RN #1 on October 11, 2011, at 3:25 p.m., in the Conference Room, confirmed RN #1 and LPN #3 reviewed the Admission Orders for transcription accuracy, and stated "LPN #3 reviewed the Admission Orders as I read the (transferring facility's) orders aloud. I did read the Coumadin 2.5 mg daily as Coumadin 12.5 mg daily and LPN #3 confirmed the Coumadin 12.5 mg daily was on our Admission Orders." Further interview confirmed RN #1 failed to verify the 12.5 mg dosage of Coumadin with the transferring facility and/or the physician upon admission.

Interview with RN #2 on October 11, 2011, at 3:50 p.m., in the Conference Room, confirmed RN #2 administered 12.5 mg of Coumadin on September 9, 2011. Continued interview confirmed RN #2 "assumed the MAR was correct," and failed to verify the 12.5 mg dosage of Coumadin with the transferring facility and/or the physician upon admission.

Interview with LPN #4 on October 11, 2011, at 4:00 p.m., in the Conference Room, confirmed LPN #4 administered 12.5 mg of Coumadin on September 8 and 10, 2011. Continued interview confirmed LPN #4 failed to verify the 12.5 mg dosage of Coumadin with the transferring facility

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F 309	Continued From page 23 and/or the physician upon admission. Interview with the NP on October 12, 2011, at 3:00 p.m, in the Conference Room, confirmed the NP was not notified of the September 8, 2011, PT/INR (19.2/1.6); was not aware of the 12.5 mg dosage of Coumadin or the resident's history just prior to admission of the Coumadin 2.5 mg being held due to elevated PT/INRs until September 11, 2011. The NP stated, "On September 11, 2011, I was notified of an elevated INR of 8.0. I came in on that date to check the resident and it was on that date I saw the 12.5 mg dosage on the Admission Orders and drew a line through it to make sure no more was given." Interview with the Director of Nursing (DON) on October 17, 2011, at 2:45 p.m., in the Conference Room, confirmed the facility failed to verify the 12.5 mg dosage of Coumadin with the transferring facility and/or the physician upon admission. Resident #9 was originally admitted to the facility on March 4, 2009, and readmitted on January 23, 2010, with diagnoses including Acute Renal Failure, Transient Ischemic Attacks, Hypertension, Coronary Artery Disease, Rhabdomyolysis, and Alzheimer's Disease. Medical record review of a Physician's Telephone Order dated July 21, 2011, at 1:00 p.m., revealed "...Continue Coumadin 5 mg po daily...Recheck PT/INR July 23, 2011..." Medical record review of the PT/INR/Coumadin Flowsheet dated July 23, 2011, revealed "...PT 38.4; INR 3.2..."	F 309		

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F 309	Continued From page 24 Medical record review of a Physician's Telephone Order dated July 23, 2011, at 3:00 p.m., revealed "...D/C Coumadin 5 mg PO daily...Coumadin 4.5 mg PO daily...Recheck PT/INR July 25, 2011..." Medical record review of the July 2011, MAR revealed Coumadin 5 mg was administered on July 23, 2011, at 5:00 p.m. Continued review revealed the Coumadin 5mg was not discontinued and Coumadin 4.5 mg was not started until July 24, 2011, at 5:00 p.m. Medical record review of the PT/INR/Coumadin Flowsheet and a Physician Telephone Order dated July 25, 2011, at 2:00 p.m., revealed PT 42.9; INR 3.6, recheck PT/INR July 27, 2011, and hold Coumadin for two days. Medical record review of a Physician's Telephone Order and the PT/INR/Coumadin Flowsheet dated July 27 (at 11:30 a.m.) and July 29, 2011, revealed PT/INRs remained elevated and the Coumadin 4.5 mg was held. Medical record review of the PT/INR/Coumadin Flowsheet dated July 29, 2011, revealed "...PT 27.0; INR 2.3..." Medical record review of Physician's Telephone Order dated July 30, 2011, at 2:00 p.m., revealed "...D/C Coumadin 4.5 mg...Start Coumadin 4 mg daily...Recheck PT/INR July 31, 2011..." Medical record review of the PT/INR/Coumadin Flowsheet and a Physician's Telephone Order dated July 31, 2011, at 10:00 a.m., revealed PT 21.7; INR 1.8, recheck PT/INR August 2, 2011, and continue Coumadin 4 mg. Medical record review of the August 2011 MARs revealed the Coumadin 4 mg was not given on August 1 and	F 309		

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F 309	Continued From page 25 2, 2011. Medical record review of the PT/INR/Coumadin Flowsheet and a Physician's Telephone Order dated August 2, 2011, at 7:00 p.m., revealed PT 16.4; INR 1.4, D/C Coumadin 4 mg, and start Coumadin 4.5 mg po daily. Medical record review of the PT/INR/Coumadin Flowsheet revealed "...August 5, 2011...PT 16.0; INR 1.3..." Medical record review of a Physician's Telephone Order dated August 6, 2011, at 12:30 p.m., revealed "...Change Coumadin 4.5 mg to 5 mg PO daily...Recheck PT/INR August 8, 2011..." Medical record review of the August 2011 MARs revealed the Coumadin 4.5 mg was discontinued on August 6, 2011. Continued review revealed the Coumadin 5 mg was not administered on August 6 and 7, 2011, as ordered by the physician, until August 8, 2011. Interview with the Director of Nursing on October 17, 2011, at 2:45 p.m., and October 18, 2011, at 11:00 a.m., in the Conference Room, confirmed the facility failed to administer the resident's Coumadin as ordered by the Physician on July 23, 2011; August 1, 2, 6, 7, 2011. Refer to F-157 (J), F-281 (D)	F 309		
F 333 SS=J	C/O #28690 483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors.	F 333		10/26/11

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F 333	Continued From page 26 This REQUIREMENT is not met as evidenced by: Based on medical record review, review of facility records, review of pharmacy policy, and interview, the facility failed to prevent three consecutive significant medications errors when administering Coumadin (a blood thinning medication) for one (#4) resident; and failed to administer Coumadin as ordered by the physician for one resident (#9) of twenty-one residents reviewed. The facility's failure to administer the correct dosage of Coumadin as ordered by the physician for one resident (#4) caused the emergency administration of Vitamin K (used to reverse the anticoagulant effects of Coumadin) for resident #4; and failure to administer Coumadin as ordered by the physician for one resident (#9) of twenty-one residents reviewed placed resident's #4 and #9 in Immediate Jeopardy (situation in which a provider's noncompliance with one or more requirements of participation has caused, or is likely to cause serious injury, harm, impairment or death). A meeting was held on October 18, 2011, at 11:45 a.m., in the Conference Room, with the Administrator, Director of Nursing, and Regional Director of Clinical Services to inform the facility of the Immediate Jeopardy. The Immediate Jeopardy was effective August 13, 2011, and is ongoing and Substandard Quality of Care. The findings included: Resident #4 was admitted to the facility on September 7, 2011, with diagnoses including Hip Joint Replacement, Severe Degenerative Joint Disease, and Transient Ischemic Attacks (a brief	F 333	F 333 SPECIFIC RESIDENTS: Resident #4's medical record was reviewed on 10-13-11 by the DON to ensure the resident was receiving the correct dosage of Coumadin as ordered by the physician. The licensed nurse was re-educated by the Director of Nursing (DON) and Assistant Director of Nursing (ADON) on 10-14-11 on accurate transcription, specifically the clarification of handwritten orders, notification of DON/MD on all Coumadin orders greater than 6mg, and the verification of all orders as they relate to hospital records and transfer orders. Resident #9's medical record was reviewed by the DON on 10-13-11to ensure the resident was receiving Coumadin as ordered by the physician. The licensed nurses were re-educated on 10-14-11 by DON and ADON on medication administration, specifically the following of physician orders, and the double-checking of admission orders and MAR reports. OTHER RESIDENTS The Regional Director of Clinical Services (RDCS) inserviced DON and Nursing Administration (Director of	

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F 333	Continued From page 27 interruption of the blood supply to part of the brain and may be a warning sign for a full-scale stroke). Medical record review of the Physician Recapitulation Orders from the transferring facility dated September 4, 2011 through September 30, 2011, revealed "...Coumadin 2.5 mg (milligrams) po(by mouth) daily (hand-written)..." Medical record review of a Nurse's Note from the transferring facility dated September 4, 2011, at 11:17 p.m., revealed "...admitted from (hospital) with total left hip replacement from degeneration...resident on Coumadin 2.5 (milligrams). PT/INR (Protime/International Normalization Ratio, test used to determine therapeutic levels for blood thinning medications) to be checked in a.m..." Medical record review of a Nurse's Note from the transferring facility dated September 5, 2011, at 12:34 a.m., revealed "...PT/INR 46.6/3.9..." Medical record review of a Physician's Telephone Order from the transferring facility dated September 5, 2011, at 11:00 a.m., revealed "...Continue to hold Coumadin today...recheck PT/INR September 6, 2011..." Medical record review of the PT/INR/Coumadin Flowsheet from the transferring facility revealed "...September 6, 2011...PT 46.8; INR 3.9...Current Dose (Coumadin) 2.5 mg...Dose Change: Hold..." Medical record review of a Physician's Telephone Order from the transferring facility dated September 6, 2011, (time is illegible) revealed	F 333	Nursing, Assistant Director of Nursing, and Unit Managers) on Coumadin protocols and procedures which included monitoring PT/INR on 10-12-11. From 10-14-11 through 10-20-11, an in-service education was completed by the SDC (Staff Development Coordinator) regarding accurate transcription, verification of medication doses, administration of medication according to physician orders, and obtaining lab results as ordered. Licensed nurses' re-education was conducted from 10-22-11 through 10-26-11by the SDC and DON including (but not limited to) monitoring for adverse effects such as signs and symptoms of bleeding, the immediate notification of the physician with change of condition, and care planning interventions for bleeding, accurate transcription, verification of medication doses, administration of medication according to physician orders, and obtaining lab results as ordered. Licensed nurses will not be allowed to work until they have been re-educated. Newly hired licensed nurses will be educated on signs and symptoms of bleeding, the immediate notification of the physician with change of condition and care planning interventions for bleeding, accurate transcription, verification of medication doses, administration of medication according	

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F 333	Continued From page 28 "...Continue to hold Coumadin...recheck PT/INR on September 8, 2011..." Medical record review of a Physician's Telephone Order from the transferring facility dated September 6, 2011, (no time) revealed "...Resident will transfer to (nursing home) on September 7, 2011, per family request...Continue all other physician orders..." Medical record review of the Admission Orders entered into the electronic charting system by Licensed Practical Nurse (LPN) #2, dated September 7, 2011, revealed "...Coumadin 12.5 mg po (by mouth) daily (a hand-written line was struck through the "12.5 mg po daily" and was illegibly initialed)...PT/INR on September 8, 2011, and call NP (Nurse Practitioner) with results prior to giving Coumadin...PT/INR every three days x (times) two weeks...PT/INR every Wednesday (start September 21, 2011)..." Medical record review of the PT/INR/Coumadin Flowsheet revealed "...September 8, 2011...PT 19.2; INR 1.6...Current Dose (Coumadin) 12.5 mg...Dose Change: (blank)..." Medical record review of the Meddication Administration Record (MAR) dated September 2011, revealed "...PT/INR on September 8, 2011, and call NP with results prior to giving Coumadin..." was initialed as completed by LPN #3. Continued review revealed the resident was administered Coumadin 12.5 mg on September 8, 9, 10, 2011. Medical record review of the PT/INR/Coumadin Flowsheet revealed "...September 11, 2011...PT	F 333	to physician orders, and obtaining lab results as ordered in orientation. As of 10-13-11, this new Coumadin process involves the following: PT/INRs to be drawn in the morning by the licensed nurse assigned to the resident. The licensed nurse assigned to the resident records the results on the PT/INR flow sheet and signs the flow sheet. The licensed nurse assigned to the resident records the results on the MAR and initials that it is completed. As of 10/13/11, Nursing Administration and the Nurse Practitioner conduct a weekday Coumadin meeting, which consists of the following: A) Review of all PT/INR results and write any new orders for Coumadin including the next scheduled PT/INR. If any Coumadin order is greater than 6mg, the DON will be notified. B) Unit Managers will compare pink anticoagulation MARs and PT/INR flow sheets with all current Coumadin orders to ensure the order is transcribed accurately to both MAR and PT/INR flow sheet. C) Orders on newly admitted residents receiving Coumadin will as of 10/13/11 be reviewed for accuracy by the Unit Managers in the Coumadin Meeting. The Coumadin orders will be compared to the original hospital orders, and if any Coumadin order is greater than 6mg, the DON will be notified. All licensed nurses were	

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F 333	Continued From page 29 96.0; INR 8.0...Current Dose (Coumadin) 12.5 mg...Dose Change: Hold Coumadin..." Medical record review of a Physician's Telephone Order dated September 11, 2011, at 2:00 p.m., revealed "...Vit (Vitamin) K 10 mg PO x 1 (one) dose now...Recheck PT/INR stat (immediately).." Medical record review of a PT/INR obtained on September 11, 2011, at 3:11 p.m., revealed "...PT > (greater than) 120.0; INR >14.0 (Therapeutic Range: PT 10.2-13.6; INR 2.0-3.5)..." Medical record review of a Physician's Telephone Order dated September 11, 2011, at 5:00 p.m., revealed "...Vit K 10 mg PO x 1 dose now...PT 116.5; INR 13.60...Recheck PT/INR 3 (three) hours after Vit K dose..." Medical record review of a PT/INR obtained on September 11, 2011, at 4:23 p.m., revealed "...PT 116.5; INR 13.6... Medical record review of a Nurse's Note dated September 11, 2011, at 10:24 p.m., revealed "...at 8:00 p.m., PT 48.1; INR 4.0..." Medical record review of a Physician's Telephone Order dated September 11, 2011, at 9:00 p.m., revealed "...Hold Coumadin September 12, 2011...PT/ INR September 12, 2011..." Medical record review of the PT/INR/Coumadin Flowsheet revealed "...September 12, 2011...PT 18.1; INR 1.5...Current Dose (Coumadin) On Hold...Dose Change: Hold Coumadin..." Medical record review of a Physician's Telephone	F 333	educated 10-22-11 through 10-26-11by the DON regarding this protocol. At the completion of the Coumadin meeting the unit manager will, as of 10/13/11, return the charts to the floor and notify the licensed nurse assigned to the resident of any orders. The licensed nurse assigned to the resident is to notify the pharmacy of any new Coumadin orders via fax. The Unit Managers are as of 10/13/11 to ensure the proper Coumadin dose is in the medication cart before the 5pm medication administration. On weekends and holidays, the Weekend Supervisor will, as of 10/13/11, collect the PT/INR flow sheet books to ensure that the PT/INRs were completed as ordered. The Weekend Supervisor will call the NP with the results of any new PT/INRs and write any new telephone orders needed The MARs will be checked to ensure that the Coumadin dose and order is transcribed accurately. The weekend supervisor will ensure that the proper Coumadin dose is in the medication cart before the 5pm medication administration. The Weekend Supervisor will be present at the Monday Coumadin meeting.	

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F 333	Continued From page 30 Order dated September 12, 2011, at 10:00 a.m., revealed "...Start Coumadin 2 mg PO daily...Start September 13, 2011...Recheck PT/ INR September 13, 2011..." Review of a facility investigation, to include Director of Nursing (DON) and Administrator investigative data review, dated September 14, 2011, and Medical Director dated October 1, 2011, revealed "...Summary of Investigative Facts: Orders from the transferring facility not clearly written for Coumadin orders. Coumadin was transcribed on physician's orders as a higher dose than ordered from the transferring facility. Coumadin was given after PT/INR was checked on September 8, 2011 as ordered from transferring facility which caused resident's PT/INR to be out of range. Vitamin K ordered on September 11, 2011, after PT/INR was ordered on that date. VSS (vital signs stable)... PT/INR out of range...NP notified...Vitamin K order... Coumadin held...PT/INR ordered...Once PT/INR was in range NP ordered correct dose to be given...Recommendations/Actions Taken: For future review if a Coumadin dose is over 10 mg, Nursing will clarify order with MD (Medical Doctor)/NP and notify DON..." Continued review revealed an attached Record of In-Service dated September 12, 2011. Continued review revealed two LPN signatures were on the In-Service Signature Sheet. Review of the facility's Current Associate (Employees) List dated October 18, 2011, revealed 68 licensed nurses employed by the facility. Review of a fax received from the pharmacy at the surveyor's request on October 10, 2011, at 3:54 p.m., revealed "...Cover Page...Comments:	F 333	Residents receiving Coumadin therapy were reviewed by the DON, NP and nurse managers on 10-13-11for PT/INR monitoring, the Coumadin order, and the MAR for accuracy. On 10-26-11 residents on Coumadin were assessed for adverse effects such as signs and symptoms of bleeding and/or bruising by LPN's, RN's and Unit Managers. Residents on Coumadin therapy are reviewed daily by Nursing Administration (Director of Nursing, Assistant Director of Nursing, Weekend Supervisor and Unit Managers) to ensure accuracy of Coumadin administration. The MAR is reviewed daily by Nursing Administration (Director of Nursing, Assistant Director of Nursing, Weekend Supervisor and Unit Managers) to ensure Coumadin had been given that day and had been documented appropriately. New physician orders are reviewed daily by Nursing Administration (Director of Nursing, Assistant Director of Nursing, Weekend Supervisor and Unit Managers) to ensure accuracy in transcription on the MAR. The medication sent from pharmacy will be checked daily by unit manager/licensed nurses to ensure the correct dose is on hand.	

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F 333	Continued From page 31 Note that the most recent policy update changed the strength to 7.5 mg on beginning patients for clarification rather than 6 mg..." Continued review revealed a policy titled "High Dose Alert Drugs and Drugs that Require Registration" dated September 4, 2008, and revealed "...1. Medications prescribed at high doses or inappropriate doses based on the patient's medical condition may require documented pharmacist intervention or acknowledgement prior to dispensing. (Pharmacy) has identified several commonly prescribed medications at high doses that can result in adverse patient outcomes (particularly in the elderly) that warrant special consideration. These drugs include the following:...e) Warfarin (Coumadin) prescribed at a total daily dose greater than 7.5 mg milligrams...2. For new orders pharmacist intervention is advised and prescriber verification documented if a patient is naïve or "new" to the drug (never taken before) or if there is a significant increase in the dose from the previous regimen..." Interview by telephone on October 10, 2011, at 3:15 p.m,, when the surveyor informed the Director of Pharmacy of the transcription error of Coumadin 12.5 mg, the Director of Pharmacy exclaimed, "Woo, that's a lot of Coumadin!" Continued interview confirmed the pharmacy sent Coumadin 10 mg and 2.5 mg to the facility. Continued interview confirmed if an order for Coumadin is over 6 mg on initial dose, it is the pharmacy's policy to call the facility, have the Nurse call the Physician and get a clarification order. The surveyor asked if the pharmacy notified the facility to clarify the Coumadin 12.5 mg and the Director of Pharmacy stated, "yes,	F 333	Newly admitted residents receiving Coumadin will have Coumadin orders verified for accuracy from transferring facility prior to admission by admission nurses. The Coumadin orders will be compared to the original transferring records. If the Coumadin dose is higher or equal to 6 milligrams, the DON will be notified for further investigation by verifying with the physician orders or contacting the admitting physician. (See Coumadin meeting process for current residents) The admission nurses/licensed nurses will verify Coumadin orders with the admitting physician on day of admission. Licensed nurses were educated on this process by the SDC and DON from 10-22-11 through 10-26-11.	

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F 333	Continued From page 32	F 333		

they would have to at that dosage on a new admission...let me get in the system and see...I don't see where it was done..." Continued interview confirmed the Pharmacy failed to notify the facility for clarification upon receiving the admission order for Coumadin 12.5 mg for the resident.

Interview with LPN #2 on October 11, 2011, at 11:40 a.m., in the Conference Room, confirmed the transferring facility's hand-written order for Coumadin 2.5 mg daily, was misread and incorrectly transcribed into the facility's electronic charting system as Coumadin 12.5 mg daily. LPN #2 stated, "I thought the orders said 12.5 mg." Continued interview confirmed LPN #2 reviewed the transferring facility's previous physician orders to hold the Coumadin and to check and recheck PT/INRs. Continued interview confirmed "When Coumadin is held and PT/INRs are being rechecked, it is because the INRs are too high from the Coumadin, the resident is getting too much Coumadin." Continued interview confirmed the Coumadin being held and the PT/INRs rechecked on a newly admitted resident did not alert or alarm LPN #2. Further interview confirmed LPN #2 failed to verify the 12.5 mg dosage of Coumadin with the transferring facility and/or the physician upon admission.

Interview with the Resident's Attending Physician (Medical Director) on October 11, 2011, at 1:30 p.m, by telephone, and on October 18, 2011, at 8:40 a.m., in the Conference Room, confirmed the Physician did review and sign the Admission Orders on September 9, 2011, and stated, "I signed the orders based on the understanding the

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F 333	Continued From page 33 Coumadin 12.5 mg daily was what the resident was receiving in the transferring facility and based on the understanding there was no transcription errors." Continued interview confirmed the Physician was unaware of a Pharmacy policy to notify the facility for verification if a patient is naïve or "new" to Coumadin or if there is a significant increase in the dose from the previous regimen. Interview with LPN #3 on October 11, 2011, at 3:00 p.m., in the Conference Room, confirmed LPN #3 notified the NP of the PT/INR results (obtained in-house) on September 8, 2011, prior to giving Coumadin. Continued interview confirmed LPN #3 and Registered Nurse (RN) #1 reviewed the Admission Orders for accuracy, and stated "I reviewed the Admission Orders as RN #1 read the (transferring facility's) orders aloud; RN #1 read the Coumadin 2.5 mg daily as Coumadin 12.5 mg daily." LPN #3 stated "When RN #1 read the 12.5 mg, I thought, that's a lot of Coumadin, but didn't say anything. If I was going to be the one giving the 12.5 mg, I would have validated why (resident) was to get 12.5 mg, but at this point, I wasn't giving it." Interview with RN #1 on October 11, 2011, at 3:25 p.m., in the Conference Room, confirmed RN #1 and LPN #3 reviewed the Admission Orders for transcription accuracy, and stated "LPN #3 reviewed the Admission Orders as I read the (transferring facility's) orders aloud. I did read the Coumadin 2.5 mg daily as Coumadin 12.5 mg daily and LPN #3 confirmed the Coumadin 12.5 mg daily was on our Admission Orders." Further interview confirmed RN #1 failed to verify the 12.5 mg dosage of Coumadin with the transferring	F 333		

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F 333	Continued From page 34 facility and/or the physician upon admission. Interview with RN #2 on October 11, 2011, at 3:50 p.m., in the Conference Room, confirmed RN #2 administered 12.5 mg of Coumadin on September 9, 2011. Continued interview confirmed RN #2 "assumed the MAR was correct," and failed to verify the 12.5 mg dosage of Coumadin with the transferring facility and/or the physician upon admission. Interview with LPN #4 on October 11, 2011, at 4:00 p.m., in the Conference Room, confirmed LPN #4 administered 12.5 mg of Coumadin on September 8 and 10, 2011. Continued interview confirmed LPN #4 failed to verify the 12.5 mg dosage of Coumadin with the transferring facility and/or the physician upon admission. Interview with the NP on October 12, 2011, at 3:00 p.m, in the Conference Room, confirmed the NP was not notified of the September 8, 2011, PT/INR (19.2/1.6); was not aware of the 12.5 mg dosage of Coumadin or the resident's history just prior to admission of the Coumadin 2.5 mg being held due to elevated PT/INRs until September 11, 2011. The NP stated, "On September 11, 2011, I was notified of an elevated INR of 8.0. I came in on that date to check the resident and it was on that date I saw the 12.5 mg dosage on the Admission Orders and drew a line through it to make sure no more was given." Interview with the DON on October 17, 2011, at 2:45 p.m., in the Conference Room, confirmed the facility failed to verify the 12.5 mg dosage of Coumadin with the transferring facility and/or the physician upon admission. Continued interview	F 333		

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F 333	Continued From page 35 confirmed the DON was unaware of a Pharmacy policy to notify the facility for verification if a patient is naïve or "new" to Coumadin or if there is a significant increase in the dose from the previous regimen. Resident #9 was originally admitted to the facility on March 4, 2009, and readmitted on January 23, 2010, with diagnoses including Acute Renal Failure, Transient Ischemic Attacks, Hypertension, Coronary Artery Disease, Rhabdomyolysis, and Alzheimer's Disease. Medical record review of a Physician's Telephone Order dated July 21, 2011, at 1:00 p.m., revealed "...Continue Coumadin 5 mg po daily...Recheck PT/INR July 23, 2011..." Medical record review of the PT/INR/Coumadin Flowsheet dated July 23, 2011, revealed "...PT 38.4; INR 3.2..." Medical record review of a Physician's Telephone Order dated July 23, 2011, at 3:00 p.m., revealed "...D/C (discontinue) Coumadin 5 mg PO daily...Coumadin 4.5 mg PO daily...Recheck PT/INR July 25, 2011..." Medical record review of the July 2011, MAR revealed Coumadin 5 mg was administered on July 23, 2011, at 5:00 p.m. Continued review revealed the Coumadin 5 mg was not discontinued and Coumadin 4.5 mg was not started until July 24, 2011, at 5:00 p.m. Medical record review of the PT/INR/Coumadin Flowsheet and a Physician Telephone Order dated July 25, 2011, at 2:00 p.m., revealed PT 42.9; INR 3.6, recheck PT/INR July 27, 2011, and hold Coumadin for two days. Medical record	F 333		

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F 333	Continued From page 36 review of a Physician's Telephone Order and the PT/INR/Coumadin Flowsheet dated July 27 (at 11:30 a.m.) and July 29, 2011, revealed PT/INRs remained elevated and the Coumadin 4.5 mg was held. Medical record review of the PT/INR/Coumadin Flowsheet dated July 29, 2011, revealed "...PT 27.0; INR 2.3..." Medical record review of Physician's Telephone Order dated July 30, 2011, at 2:00 p.m., revealed "...D/C Coumadin 4.5 mg...Start Coumadin 4 mg daily...Recheck PT/INR July 31, 2011..." Medical record review of the PT/INR/Coumadin Flowsheet and a Physician's Telephone Order dated July 31, 2011, at 10:00 a.m., revealed PT 21.7; INR 1.8, recheck PT/INR August 2, 2011, and continue Coumadin 4 mg. Medical record review of the August 2011 MARs revealed the Coumadin 4 mg was not given on August 1 and 2, 2011. Medical record review of the PT/INR/Coumadin Flowsheet and a Physician's Telephone Order dated August 2, 2011, at 7:00 p.m., revealed PT 16.4; INR 1.4, D/C Coumadin 4 mg, and start Coumadin 4.5 mg po daily. Medical record review of the PT/INR/Coumadin Flowsheet revealed "...August 5, 2011...PT 16.0; INR 1.3..." Medical record review of a Physician's Telephone Order dated August 6, 2011, at 12:30 p.m., revealed "...Change Coumadin 4.5 mg to 5 mg PO daily...Recheck PT/INR August 8, 2011..." Medical record review of the August 2011 MARs revealed the Coumadin 4.5 mg was discontinued on August 6, 2011. Continued review revealed	F 333		

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F 333	Continued From page 37 the Coumadin 5 mg was not administered on August 6 and 7, 2011, as ordered by the physician, until August 8, 2011. Interview with the Director of Nursing on October 17, 2011, at 2:45 p.m., in the Conference Room, confirmed the facility failed to administer the resident's Coumadin as ordered by the Physician on July 23, 2011; August 1, 2, 6, 7, 2011. Refer to F-157 (J), F-281 (D); F-309 (J)	F 333		
F 425 SS=J	C/O #28690 483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility.	F 425	F 425 SPECIFIC RESIDENTS Resident #4's medical record was reviewed by the pharmacist on 10-26-11. There were no further irregularities.. Operational Pharmacists from both Tennessee pharmacies were re-educated on their policy regarding high alert medications by the general manager and/or pharmacist in charge on October 11 and 12, 2011. This policy states that 1) Medications prescribed at high doses based on the patient's medical condition may require documented pharmacist intervention or acknowledgement prior to dispensing. Pharmacy has identified several commonly prescribed medications at high doses that can result in adverse patient outcomes (particularly in the elderly) that warrant special consideration. These drugs include the	10/26/11

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F 425	Continued From page 38 This REQUIREMENT is not met as evidenced by: Based on medical record review, review of facility records, review of pharmacy reports, review of pharmacy policy, and interview, the facility failed to ensure the dispensing Pharmacists followed Pharmacy policy and acted upon receiving an admission order for a high dose of Coumadin for a newly admitted resident (#4) resulting in three consecutive significant medication errors; and failed to ensure a process was in place to identify and report significant medication errors for one resident (#9) receiving Coumadin of twenty-one residents reviewed. The Pharmacy's failure to follow policy caused the emergency administration of Vitamin K (used to reverse the anticoagulant effects of Coumadin) for resident #4; and failure to identify and report significant medication errors with Coumadin as ordered by the physician for one resident (#9) of twenty-one residents reviewed placed resident's #4 and #9 in Immediate Jeopardy (situation in which a provider's noncompliance with one or more requirements of participation has caused, or is likely to cause serious injury, harm, impairment or death). A meeting was held on October 18, 2011, at 11:45 a.m., in the Conference Room, with the Administrator, Director of Nursing, and Regional Director of Clinical Services to inform the facility of the Immediate Jeopardy. The Immediate Jeopardy was effective August 13, 2011, and is ongoing. The findings included: Resident #4 was admitted to the facility on	F 425	following....e) Warfarin prescribed at a total daily dose greater than 7.5 mg (milligrams). Pharmacists will clarify Warfarin orders that exceed a total daily dose of 7.5 mg with the facility/prescriber when not provided with sufficient clinical information. The pharmacy will contact the facility first, then, if unable to reach the facility, if further clarification is needed or the facility requests, the provider will be contacted. When high dose Warfarin orders are clarified, Pharmacists will document their interventions and outcomes in the pharmacy dispensing system as appropriate, including the name of the facility staff contacted, date and time. The Consultant Pharmacist was re-educated on the Warfarin Best Practice by the Consultant Coordinator on October 25 and 26, 2011. This education included: It is expected that Consultant pharmacists play an important role in Warfarin safety by: 1) determining that the facility has a system in place for the safe and effective administration, management and monitoring of Warfarin, 2) verifying that the facility is receiving appropriate Warfarin drug interaction notification from the pharmacy, 3) anticipating and intervening to avert potential Warfarin drug interactions with follow-up documentation and 4)	

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F 425	Continued From page 39 September 7, 2011, with diagnoses including Hip Joint Replacement, Severe Degenerative Joint Disease, and Transient Ischemic Attacks (a brief interruption of the blood supply to part of the brain and may be a warning sign for a full-scale stroke). Medical record review of the Physician Recapitulation Orders from the transferring facility dated September 4, 2011 through September 30, 2011, revealed "...Coumadin 2.5 mg (milligrams) po (by mouth) daily (hand-written)..." Medical record review of a Nurse's Note from the transferring facility dated September 4, 2011, at 11:17 p.m., revealed "...admitted from (hospital) with total left hip replacement from degeneration...resident on Coumadin 2.5 (milligrams). PT/INR (Protime/International Normalization Ratio, test used to determine therapeutic levels for blood thinning medications) to be checked in a.m..." Medical record review of a Nurse's Note from the transferring facility dated September 5, 2011, at 12:34 a.m., revealed "...PT/INR 46.6/3.9..." Medical record review of a Physician's Telephone Order from the transferring facility dated September 5, 2011, at 11:00 a.m., revealed "...Continue to hold Coumadin today...recheck PT/INR September 6, 2011..." Medical record review of the PT/INR/Coumadin Flowsheet from the transferring facility revealed "...September 6, 2011...PT 46.8; INR 3.9...Current Dose (Coumadin) 2.5 mg...Dose Change: Hold..."	F 425	providing quality assurance reporting and follow-up to the facility. Resident #9's medical record was reviewed by the pharmacist on 10-26-11. There were no further irregularities. OTHER RESIDENTS Residents on Coumadin have the potential to be affected. The pharmacy will identify all residents using Warfarin during medication regimen review and will communicate all identified irregularities in writing and verbally to NF Director of Nursing and Administrator for action and possible execution at time of review. If there are irregularities found by the Consultant Pharmacist, the facility will educate, review and revise processes as needed. Other options may include notification of MD and investigations and/or corrective actions as warranted. Residents receiving Coumadin therapy were reviewed by the DON, NP and Nursing Administration (ADON, Unit Managers, Weekend Supervisor) on 10-13-11for PT/INR monitoring, the Coumadin order, and the Medication Administration Review (MAR) for accuracy. On 10-26-11 residents on Coumadin were assessed for monitoring for	

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F 425	Continued From page 40 Medical record review of a Physician's Telephone Order from the transferring facility dated September 6, 2011, (time is illegible) revealed "...Continue to hold Coumadin...recheck PT/INR on September 8, 2011..." Medical record review of a Physician's Telephone Order from the transferring facility dated September 6, 2011, (no time) revealed "...Resident will transfer to (nursing home) on September 7, 2011, per family request...Continue all other physician orders..." Medical record review of the Admission Orders entered into the electronic charting system by Licensed Practical Nurse (LPN) #2, dated September 7, 2011, revealed "...Coumadin 12.5 mg po daily (a hand-written line was struck through the "12.5 mg po daily" and was illegibly initialed)...PT/INR on September 8, 2011, and call NP (Nurse Practitioner) with results prior to giving Coumadin...PT/INR every three days x (times) two weeks...PT/INR every Wednesday (start September 21, 2011)..." Medical record review of the PT/INR/Coumadin Flowsheet revealed "...September 8, 2011...PT 19.2; INR 1.6...Current Dose (Coumadin) 12.5 mg...Dose Change: (blank)..." Medical record review of the Medication Administration Record (MAR) dated September 2011, revealed "...PT/INR on September 8, 2011, and call NP with results prior to giving Coumadin..." was initialed as completed by LPN #3. Continued review revealed the resident was administered Coumadin 12.5 mg on September 8, 9, 10, 2011.	F 425	adverse effects such as signs and symptoms of bleeding and/or bruising. The pharmacist reviewed medical records of residents on Coumadin therapy for accuracy on 10-26-11. No further irregularities were found. The ED and the DON met with the Consultant Pharmacist on 10-26-11. Every resident on Coumadin will be reviewed monthly which will include the PT/INR Flow Sheets, residents' charts, MAR, nurses' notes, and Vitamin K usage. All findings and recommendations are documented on the Pharmacy Report and Recommendation sheets and give the report to the ED and DON. The facility will educate, review and revise processes as needed. Other options may include notification of MD and investigations and/or corrective actions as warranted ED reviewed the pharmacy contract and the pharmacy regulation F425 with the Consultant Pharmacist on 10-26-11.	

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F 425	Continued From page 41 Medical record review of the PT/INR/Coumadin Flowsheet revealed "...September 11, 2011...PT 96.0; INR 8.0...Current Dose (Coumadin) 12.5 mg...Dose Change: Hold Coumadin..." Medical record review of a Physician's Telephone Order dated September 11, 2011, at 2:00 p.m., revealed "...Vit (vitamin) K 10 mg PO x 1 (one) dose now...Recheck PT/INR stat (immediately).." Medical record review of a PT/INR obtained on September 11, 2011, at 3:11 p.m., revealed "...PT > (greater than) 120.0; INR >14.0 (Therapeutic Range: PT 10.2-13.6; INR 2.0-3.5)..." Medical record review of a Physician's Telephone Order dated September 11, 2011, at 5:00 p.m., revealed "...Vit K 10 mg PO x 1 dose now...PT 116.5; INR 13.60...Recheck PT/INR 3 (three) hours after Vit K dose..." Medical record review of a PT/INR obtained on September 11, 2011, at 4:23 p.m., revealed "...PT 116.5; INR 13.6... Medical record review of a Nurse's Note dated September 11, 2011, at 10:24 p.m., revealed "...at 8:00 p.m., PT 48.1; INR 4.0..." Medical record review of a Physician's Telephone Order dated September 11, 2011, at 9:00 p.m., revealed "...Hold Coumadin September 12, 2011...PT/ INR September 12, 2011..." Medical record review of the PT/INR/Coumadin Flowsheet revealed "...September 12, 2011...PT 18.1; INR 1.5...Current Dose (Coumadin) On	F 425		

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F 425	Continued From page 42 Hold...Dose Change: Hold Coumadin..." Medical record review of a Physician's Telephone Order dated September 12, 2011, at 10:00 a.m., revealed "...Start Coumadin 2 mg PO daily...Start September 13, 2011...Recheck PT/ INR September 13, 2011..." Review of a facility investigation, to include DON (Director of Nursing) and Administrator investigative data review, dated September 14, 2011, and Medical Director dated October 1, 2011, revealed "...Summary of Investigative Facts: Orders from the transferring facility not clearly written for Coumadin orders. Coumadin was transcribed on physician's orders as a higher dose than ordered from the transferring facility. Coumadin was given after PT/INR was checked on September 8, 2011 as ordered from transferring facility which caused resident's PT/INR to be out of range. Vitamin K ordered on September 11, 2011, after PT/INR was ordered on that date. VSS (vital signs stable)... PT/INR out of range...NP notified...Vitamin K order... Coumadin held...PT/INR ordered...Once PT/INR was in range NP ordered correct dose to be given...Recommendations/Actions Taken: For future review if a Coumadin dose is over 10 mg, Nursing will clarify order with MD (Medical Doctor)/NP (Nurse Practioner) and notify DON..." Continued review revealed an attached Record of In-Service dated September 12, 2011. Continued review revealed two LPN signatures were on the In-Service Signature Sheet. Review of the facility's Current Associate (Employees) List dated October 18, 2011, revealed 68 licensed nurses employed by the facility.	F 425		

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F 425	Continued From page 43 Review of a fax received from the pharmacy at the surveyor's request on October 10, 2011, at 3:54 p.m., revealed "...Cover Page...Comments: Note that the most recent policy update changed the strength to 7.5 mg on beginning patients for clarification rather than 6 mg..." Continued review revealed a policy titled "High Dose Alert Drugs and Drugs that Require Registration" dated September 4, 2008, and revealed "...1. Medications prescribed at high doses or inappropriate doses based on the patient's medical condition may require documented pharmacist intervention or acknowledgement prior to dispensing. (Pharmacy) has identified several commonly prescribed medications at high doses that can result in adverse patient outcomes (particularly in the elderly) that warrant special consideration. These drugs include the following:...e) Warfarin (Coumadin) prescribed at a total daily dose greater than 7.5 mg milligrams...2. For new orders pharmacist intervention is advised and prescriber verification documented if a patient is naïve or "new" to the drug (never taken before) or if there is a significant increase in the dose from the previous regimen..." Interview by telephone on October 10, 2011, at 3:15 p.m,, when the surveyor informed the Director of Pharmacy of the transcription error of Coumadin 12.5 mg, the Director of Pharmacy exclaimed, "Woo, that's a lot of Coumadin!" Continued interview confirmed the pharmacy sent Coumadin 10 mg and 2.5 mg to the facility. Continued interview confirmed if an order for Coumadin is over 6 mg on initial dose, it is the pharmacy's policy to call the facility, have the Nurse call the Physician and get a clarification	F 425		

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F 425	Continued From page 44 order. The surveyor asked if the pharmacy notified the facility to clarify the Coumadin 12.5 mg and the Director of Pharmacy stated, "yes, they would have to at that dosage on a new admission...let me get in the system and see...I don't see where it was done..." Continued interview confirmed the Pharmacy failed to notify the facility for clarification upon receiving the admission order for Coumadin 12.5 mg for the resident. Interview with LPN #2 on October 11, 2011, at 11:40 a.m., in the Conference Room, confirmed the transferring facility's hand-written order for Coumadin 2.5 mg daily, was misread and incorrectly transcribed into the facility's electronic charting system as Coumadin 12.5 mg daily. LPN #2 stated, "I thought the orders said 12.5 mg." Continued interview confirmed LPN #2 reviewed the transferring facility's previous physician orders to hold the Coumadin and to check and recheck PT/INRs. Continued interview confirmed "When Coumadin is held and PT/INRs are being rechecked, it is because the INRs are too high from the Coumadin, the resident is getting too much Coumadin." Continued interview confirmed the Coumadin being held and the PT/INRs rechecked on a newly admitted resident did not alert or alarm LPN #2. Further interview confirmed LPN #2 failed to verify the 12.5 mg dosage of Coumadin with the transferring facility and/or the physician upon admission. Interview with the Resident's Attending Physician (Medical Director) on October 11, 2011, at 1:30 p.m, by telephone, and on October 18, 2011, at 8:40 a.m., in the Conference Room, confirmed	F 425		

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F 425	Continued From page 45 the Physician did review and sign the Admission Orders on September 9, 2011, and stated, "I signed the orders based on the understanding the Coumadin 12.5 mg daily was what the resident was receiving in the transferring facility and based on the understanding there was no transcription errors." Continued interview confirmed the Physician was unaware of a Pharmacy policy to notify the facility for verification if a patient is naïve or "new" to Coumadin or if there is a significant increase in the dose from the previous regimen. Interview with LPN #3 on October 11, 2011, at 3:00 p.m., in the Conference Room, confirmed LPN #3 notified the NP of the PT/INR results (obtained in-house) on September 8, 2011, prior to giving Coumadin. Continued interview confirmed LPN #3 and Registered Nurse (RN) #1 reviewed the Admission Orders for accuracy, and stated "I reviewed the Admission Orders as RN #1 read the (transferring facility's) orders aloud; RN #1 read the Coumadin 2.5 mg daily as Coumadin 12.5 mg daily." LPN #3 stated "When RN #1 read the 12.5 mg, I thought, that's a lot of Coumadin, but didn't say anything. If I was going to be the one giving the 12.5 mg, I would have validated why (resident) was to get 12.5 mg, but at this point, I wasn't giving it." Interview with RN #1 on October 11, 2011, at 3:25 p.m., in the Conference Room, confirmed RN #1 and LPN #3 reviewed the Admission Orders for transcription accuracy, and stated "LPN #3 reviewed the Admission Orders as I read the (transferring facility's) orders aloud. I did read the Coumadin 2.5 mg daily as Coumadin 12.5 mg daily and LPN #3 confirmed the Coumadin 12.5	F 425		

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F 425	Continued From page 46 mg daily was on our Admission Orders." Further interview confirmed RN #1 failed to verify the 12.5 mg dosage of Coumadin with the transferring facility and/or the physician upon admission. Interview with RN #2 on October 11, 2011, at 3:50 p.m., in the Conference Room, confirmed RN #2 administered 12.5 mg of Coumadin on September 9, 2011. Continued interview confirmed RN #2 "assumed the MAR was correct," and failed to verify the 12.5 mg dosage of Coumadin with the transferring facility and/or the physician upon admission. Interview with LPN #4 on October 11, 2011, at 4:00 p.m., in the Conference Room, confirmed LPN #4 administered 12.5 mg of Coumadin on September 8 and 10, 2011. Continued interview confirmed LPN #4 failed to verify the 12.5 mg dosage of Coumadin with the transferring facility and/or the physician upon admission. Interview with the NP on October 12, 2011, at 3:00 p.m, in the Conference Room, confirmed the NP was not notified of the September 8, 2011, PT/INR (19.2/1.6); was not aware of the 12.5 mg dosage of Coumadin or the resident's history just prior to admission of the Coumadin 2.5 mg being held due to elevated PT/INRs until September 11, 2011. The NP stated, "On September 11, 2011, I was notified of an elevated INR of 8.0. I came in on that date to check the resident and it was on that date I saw the 12.5 mg dosage on the Admission Orders and drew a line through it to make sure no more was given." Interview with the Director of Nursing (DON) on October 17, 2011, at 2:45 p.m., in the Conference	F 425		

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F 425	Continued From page 47	F 425		

Room, confirmed the facility failed to verify the 12.5 mg dosage of Coumadin with the transferring facility and/or the physician upon admission. Continued interview confirmed the DON was unaware of a Pharmacy policy to notify the facility for verification if a patient is naïve or "new" to Coumadin or if there is a significant increase in the dose from the previous regimen.

Resident #9 was originally admitted to the facility on March 4, 2009, and readmitted on January 23, 2010, with diagnoses including Acute Renal Failure, Transient Ischemic Attacks, Hypertension, Coronary Artery Disease, Rhabdomyolysis, and Alzheimer's Disease.

Medical record review of a Physician's Telephone Order dated July 21, 2011, at 1:00 p.m., revealed "...Continue Coumadin 5 mg po daily...Recheck PT/INR July 23, 2011..."

Medical record review of the PT/INR/Coumadin Flowsheet dated July 23, 2011, revealed "...PT 38.4; INR 3.2..."

Medical record review of a Physician's Telephone Order dated July 23, 2011, at 3:00 p.m., revealed "...D/C (discontinue) Coumadin 5 mg PO daily...Coumadin 4.5 mg PO daily...Recheck PT/INR July 25, 2011..." Medical record review of the July 2011, MAR revealed Coumadin 5 mg was administered on July 23, 2011, at 5:00 p.m. Continued review revealed the Coumadin 5mg was not discontinued and Coumadin 4.5 mg was not started until July 24, 2011, at 5:00 p.m.

Medical record review of the PT/INR/Coumadin Flowsheet and a Physician Telephone Order

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F 425	Continued From page 48 dated July 25, 2011, at 2:00 p.m., revealed PT 42.9; INR 3.6, recheck PT/INR July 27, 2011, and hold Coumadin for two days. Medical record review of a Physician's Telephone Order and the PT/INR/Coumadin Flowsheet dated July 27 (at 11:30 a.m.) and July 29, 2011, revealed PT/INRs remained elevated and the Coumadin 4.5 mg was held. Medical record review of the PT/INR/Coumadin Flowsheet dated July 29, 2011, revealed "...PT 27.0; INR 2.3..." Medical record review of Physician's Telephone Order dated July 30, 2011, at 2:00 p.m., revealed "...D/C Coumadin 4.5 mg...Start Coumadin 4 mg daily...Recheck PT/INR July 31, 2011..." Medical record review of the PT/INR/Coumadin Flowsheet and a Physician's Telephone Order dated July 31, 2011, at 10:00 a.m., revealed PT 21.7; INR 1.8, recheck PT/INR August 2, 2011, and continue Coumadin 4 mg. Medical record review of the August 2011 MARs revealed the Coumadin 4 mg was not given on August 1 and 2, 2011. Medical record review of the PT/INR/Coumadin Flowsheet and a Physician's Telephone Order dated August 2, 2011, at 7:00 p.m., revealed PT 16.4; INR 1.4, D/C Coumadin 4 mg, and start Coumadin 4.5 mg po daily. Medical record review of the PT/INR/Coumadin Flowsheet revealed "...August 5, 2011...PT 16.0; INR 1.3..." Medical record review of a Physician's Telephone Order dated August 6, 2011, at 12:30 p.m., revealed "...Change Coumadin 4.5 mg to 5 mg PO daily...Recheck PT/INR August 8, 2011..."	F 425		

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F 425	Continued From page 49 Medical record review of the August 2011 MARs revealed the Coumadin 4.5 mg was discontinued on August 6, 2011. Continued review revealed the Coumadin 5 mg was not administered on August 6 and 7, 2011, as ordered by the physician, until August 8, 2011. Review of the Consultant Pharmacist Reports July and August 2011, revealed no documentation of the significant medication errors. Interview with the Director of Nursing on October 17, 2011, at 2:45 p.m., and October 18, 2011, at 11:00 a.m., in the Conference Room, confirmed the facility failed to administer the resident's Coumadin as ordered by the Physician on July 23, 2011; August 1, 2, 6, 7, 2011. Interview by telephone with the facility's Pharmacy Consultant on October 18, 2011, at 3:02 p.m., lasted one minute and fifteen seconds, allowing enough time to introduce the surveyor to the Consultant and the surveyor began to interview the Consultant about the facility's medication errors and the Consultant's role in the facility's QA (Quality Assurance) program, and the call was ended, but not by the surveyor. The surveyor immediately called the Consultant back and after numerous rings, the call went to the Consultant's voicemail and a message was left explaining the surveyor's position and the need to interview the Consultant regarding the provision of consultative services. The Consultant Pharmacist never returned the surveyor's call as requested. Refer to F-157 (J), F-281 (D); F-309 (J) and	F 425		

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F 425	Continued From page 50 F-333 (J)-Substandard Quality of Care C/O #28690 483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on medical record review, review of facility records and contracts, review of pharmacy policy, and interview, the facility failed to be administered in a manner to identify and ensure processes were in place to train and educate staff on bleeding and bleeding precautions associated with anticoagulation therapy, notify the physician of a change in condition, and failure to monitor the blood thinner levels as ordered by the physician resulting in active bleeding in the mouth and a transfer to the hospital emergency room for evaluation for one resident (#8); failure to administer the correct dosage of Coumadin as ordered by the physician for one resident (#4); and failure to administer Coumadin as ordered by the physician for one resident (#9) of twenty-one residents reviewed which placed resident's #8, #4, #9 in Immediate Jeopardy (situation in which a provider's noncompliance with one or more requirements of participation has caused, or is likely to cause serious injury, harm, impairment or death).	F 490	F 490 SPECIFIC RESIDENTS Resident #8's care plan was updated 8/25/11 to include interventions for adverse effects of Coumadin such as bleeding. On 8-21-11, Resident #8 had a 6.9 Prothrombin and International Normalization (PT/INR). The physician was notified of the change in condition, and an order was received for 10 mg of Vitamin K. 10 mg of Vitamin K was administered by the Licensed Nurse. Resident was transferred on 8-21-11 to Emergency Room where a PT/INR test was completed with an INR result of 2.8. The resident's PT/INR result continues to be monitored as ordered. The licensed nurse was re-educated by the Director of Nursing (DON) and Assistant Director of Nursing (ADON) on 10-21-11 on physician notification of change of condition. The pharmacist reviewed the clinical record on 10-26-11. No further irregularities were found. Resident #4's medical record was reviewed on 10-13-11 by the DON to ensure the resident was receiving the correct dosage of Coumadin as ordered by the physician. The licensed nurse was re-educated by the Director of Nursing (DON) and Assistant Director	10/26/11

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F 490	Continued From page 51 A meeting was held on October 18, 2011, at 11:45 a.m., in the Conference Room, with the Administrator, Director of Nursing, and Regional Director of Clinical Services to inform the facility of the Immediate Jeopardy. The Immediate Jeopardy was effective August 13, 2011, and is ongoing. The findings included: Interview with the Administrator on October 18, 2011, at 2:00 p.m., in the Conference Room, confirmed the facility failed to obtain the Protime/International Normalization Ratio (PT/INR) (lab test used to determine therapeutic levels for blood thinning medications) on August 20, 2011, for resident #8 on Coumadin (blood thinning medications) Therapy. Continued interview confirmed the facility failed to careplan on bleeding precautions or interventions. Continued interview confirmed the Administrator was unaware resident #8 required administration of Vitamin K due to an elevated PT/INR and was sent to the Emergency Room for an elevated PT/INR and bleeding around the mouth on August 21, 2011. Continued interview with the Administrator confirmed the facility failed to provide the correct dose of Coumadin to resident #4 for three consecutive days. The Administrator confirmed only two licensed nurses were inserviced after resident #4 received an incorrect dose of Coumadin and additional training did not begin until the surveyor brought it to the attention of the Director of Nursing on October 10, 2011. Continued interview confirmed the Administrator was unaware of a Pharmacy policy to notify the facility for verification if a patient is naive or "new"	F 490	of Nursing (ADON) on 10-14-11 on accurate transcription. Resident #9's medical record was reviewed on 10-13-11to ensure the resident was receiving Coumadin as ordered by the physician. The licensed nurses were re-educated on 10-20-11 on medication administration. OTHER RESIDENTS Residents on Coumadin have the potential to be affected. Residents receiving Coumadin therapy were reviewed by the DON, NP and nurse managers on 10-13-11 for PT/INR monitoring, the Coumadin order, and the MAR for accuracy. On 10-26-11 residents on Coumadin were assessed for monitoring for adverse effects such as signs and symptoms of bleeding and/or bruising. Care plans were updated by nurse managers on 10-25-11 for interventions for bleeding precautions The Divisional Vice President (DVP) and the Divisional Director of Clinical Services (DDCS) inserviced the Executive Director on Coumadin protocols and procedures which included monitoring PT/INR, signs and symptoms of bleeding, care plan interventions, notify the physician of change of condition,	

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F 490	Continued From page 51 A meeting was held on October 18, 2011, at 11:45 a.m., in the Conference Room, with the Administrator, Director of Nursing, and Regional Director of Clinical Services to inform the facility of the Immediate Jeopardy. The Immediate Jeopardy was effective August 13, 2011, and is ongoing. The findings included: Interview with the Administrator on October 18, 2011, at 2:00 p.m., in the Conference Room, confirmed the facility failed to obtain the Protime/International Normalization Ratio (PT/INR) (lab test used to determine therapeutic levels for blood thinning medications) on August 20, 2011, for resident #8 on Coumadin (blood thinning medications) Therapy. Continued interview confirmed the facility failed to careplan on bleeding precautions or interventions. Continued interview confirmed the Administrator was unaware resident #8 required administration of Vitamin K due to an elevated PT/INR and was sent to the Emergency Room for an elevated PT/INR and bleeding around the mouth on August 21, 2011. Continued interview with the Administrator confirmed the facility failed to provide the correct dose of Coumadin to resident #4 for three consecutive days. The Administrator confirmed only two licensed nurses were inserviced after resident #4 received an incorrect dose of Coumadin and additional training did not begin until the surveyor brought it to the attention of the Director of Nursing on October 10, 2011. Continued interview confirmed the Administrator was unaware of a Pharmacy policy to notify the facility for verification if a patient is naïve or "new"	F 490	administer the correct dose of Coumadin and administering the Coumadin as ordered on October 25, 2011. As of 10-13-11, this new Coumadin process involves the following: PT/INRs to be drawn in the morning by the licensed nurse assigned to the resident. The licensed nurse assigned to the resident records the results on the PT/INR flow sheet and signs the flow sheet. The licensed nurse assigned to the resident records the results on the MAR and initials that it is completed. As of 10/13/11, Nursing Administration and the Nurse Practitioner conduct a weekday Coumadin meeting, which consists of the following: A) Review of all PT/INR results and write any new orders for Coumadin including the next scheduled PT/INR. If any Coumadin order is greater than 6mg, the DON will be notified. B) Unit Managers will compare pink anticoagulation MARs and PT/INR flow sheets with all current Coumadin orders to ensure the order is transcribed accurately to both MAR and PT/INR flow sheet. C) Orders on newly admitted residents receiving Coumadin will as of 10/13/11 be reviewed for accuracy by the Unit Managers in the Coumadin Meeting. The Coumadin orders will be compared to the original hospital orders, and if any Coumadin	

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F 490	Continued From page 51 A meeting was held on October 18, 2011, at 11:45 a.m., in the Conference Room, with the Administrator, Director of Nursing, and Regional Director of Clinical Services to inform the facility of the Immediate Jeopardy. The Immediate Jeopardy was effective August 13, 2011, and is ongoing. The findings included: Interview with the Administrator on October 18, 2011, at 2:00 p.m., in the Conference Room, confirmed the facility failed to obtain the Protime/International Normalization Ratio (PT/INR) (lab test used to determine therapeutic levels for blood thinning medications) on August 20, 2011, for resident #8 on Coumadin (blood thinning medications) Therapy. Continued interview confirmed the facility failed to careplan on bleeding precautions or interventions. Continued interview confirmed the Administrator was unaware resident #8 required administration of Vitamin K due to an elevated PT/INR and was sent to the Emergency Room for an elevated PT/INR and bleeding around the mouth on August 21, 2011. Continued interview with the Administrator confirmed the facility failed to provide the correct dose of Coumadin to resident #4 for three consecutive days. The Administrator confirmed only two licensed nurses were inserviced after resident #4 received an incorrect dose of Coumadin and additional training did not begin until the surveyor brought it to the attention of the Director of Nursing on October 10, 2011. Continued interview confirmed the Administrator was unaware of a Pharmacy policy to notify the facility for verification if a patient is naïve or "new"	F 490	order is greater than 6mg, the DON will be notified. All licensed nurses were educated 10-22-11 through 10-26-11by the DON regarding this protocol. The Executive Director will review the Coumadin Audit for compliance on weekdays. The ED gave the pharmacist consultant the schedule of the Quality Assurance meetings for their participation on 10-26-11. A Quality Assurance meeting was held on 10-21-11 which included the Coumadin process of monitoring PT/INRs and verifying dosage and administration, educating staff on signs and symptoms of bleeding and and the immediate notification of the physician for change of residents' condition. MARs will be checked to ensure that the Coumadin dose and order is transcribed accurately. The weekend supervisor will ensure that the proper Coumadin dose is in the medication cart before the 5pm medication administration. The Weekend Supervisor will be present at the Monday Coumadin meeting. The Executive Director will review the Coumadin Meeting audit sheet for compliance on week day	

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F 490	Continued From page 52 to Coumadin or if there is a significant increase in the dose from the previous regimen. Continued interview confirmed the facility's Pharmacy Services Agreement would ensure a representative from the Pharmacy is available for attendance at the facility's Quality Assurance (QA) Committee Meetings, but a representative has attended only two monthly QA Meetings since March 2011. Refer to F-157 (J), F-281 (D); F-309 (J) and F-333 (J)-Substandard Quality of Care; F-425 (J) C/O #28690	F 490		
F 502 SS=D	483.75(j)(1) ADMINISTRATION The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to monitor the Protime/International Normalization Ratio (PT/INR-lab test used to determine therapeutic levels for blood thinning medications) as ordered by the physician for one resident (#8) of twenty-one residents reviewed. The findings included: Resident #8 was admitted to the facility on August 12, 2011, with diagnoses including Atrial Fibrillation, Hypertension, Late-Effects Hemiplegia (paralysis affecting only one side of	F 502		

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F 502	Continued From page 53 the body), and Neuralgia. Medical record review of the PT/INR/Coumadin Flowsheet revealed "...August 19, 2011...PT 56.7; INR 4.7...Current Dose (Coumadin) 5 mg...Dose Change: Hold..." Medical record review of a Physician's Telephone Order dated August 19, 2011, at 1:20 p.m., revealed "...Hold all Coumadin for today. Next PT/INR on August 20, 2011..." Medical record review of the PT/INR Flowsheets, Medication Administration Records (MARs), Treatment Administration Records (TARs), Nurse's Notes and review of the facility's 24-Hour Report revealed no documentation the PT/INR was completed on August 20, 2011. Interview with the Director of Nursing (DON) on October 17, 2011, at 2:45 p.m., in the Conference Room, confirmed PT/INR's are done in-house unless otherwise ordered by the physician and confirmed the facility had failed to obtain the PT/INR on August 20, 2011, for the resident on Coumadin Therapy. Interview with the Administrator on October 18, 2011, at 2:00 p.m., in the Conference Room, confirmed the facility failed to obtain the PT/INR on August 20, 2011, for the resident on Coumadin Therapy. Refer to F-157 (J), F-281 (D); F-309 (J) and F-333 (J)-Substandard Quality of Care; F-425 (J), F-490 (J)	F 502		
F 520 SS=J	C/O #28690 483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET	F 520		10/26/11

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F 520	Continued From page 54 QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on medical record review, review of facility records and contracts, review of pharmacy policy, and interview, the facility failed to ensure the Quality Assurance (QA) Committee identified and implemented a plan to train and educate the staff on bleeding and bleeding precautions, notify the physician of a change in condition, and to monitor the blood thinner levels as ordered by the physician resulted in active bleeding in the mouth	F 520	F 520 SPECIFIC RESIDENTS Resident #8's care plan was updated 8/25/11 to include interventions for adverse effects of Coumadin such as bleeding. On 8-21-11, Resident #8 had a 6.9 Prothrombin and International Normalization (PT/INR). The physician was notified of the change in condition, and an order was received for 10 mg of Vitamin K. 10 mg of Vitamin K was administered by the Licensed Nurse. Resident was transferred on 8-21-11 to Emergency Room where a PT/INR test was completed with an INR result of 2.8. The resident's PT/INR result continues to be monitored as ordered. The licensed nurse was re-educated by the Director of Nursing (DON) and Assistant Director of Nursing (ADON) on 10-21-11 on physician notification of change of condition. Resident #4's medical record was reviewed on 10-13-11 by the DON to ensure the resident was receiving the correct dosage of Coumadin as ordered by the physician. The licensed nurse was re-educated by the Director of Nursing (DON) and Assistant Director of Nursing (ADON) on 10-14-11. Resident #9's medical record was reviewed 10-13-11 by the DON on to	

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F 520	Continued From page 55 and a transfer to the hospital emergency room for evaluation for one resident (#8); and to administer the correct dosage of Coumadin as ordered by the physician for one resident (#4); and to administer Coumadin as ordered by the physician for one resident (#9) of twenty-one residents reviewed placed resident's #8, #4, #9 in Immediate Jeopardy (situation in which a provider's noncompliance with one or more requirements of participation has caused, or is likely to cause serious injury, harm, impairment or death). A meeting was held on October 18, 2011, at 11:45 a.m., in the Conference Room, with the Administrator, Director of Nursing, and Regional Director of Clinical Services to inform the facility of the Immediate Jeopardy. The Immediate Jeopardy was effective August 13, 2011, and is ongoing. The findings included: Interview with the Resident's Attending Physician (Medical Director) on October 18, 2011, at 8:40 a.m, in the Conference Room, confirmed the facility failed to accurately transcribed Coumadin (blood thinning medication) 2.5 mg (milligram) as Coumadin 12.5 mg for resident #4. Continued interview confirmed the facility did not hold a QA Meeting and discuss this significant medication error until October 12, 2011. Continued interview confirmed the Medical Director did not recall the Pharmacist or a pharmacy representative in attendance at the QA Meeting on October 12, 2011. Continued interview with the Medical Director confirmed the significant medication error on resident #4 was serious and warranted	F 520	ensure the resident was receiving Coumadin as ordered by the physician. The licensed nurses were re-educated on 10-20-11. OTHER RESIDENTS Residents on Coumadin have the potential to be affected. Residents receiving Coumadin therapy were reviewed by the DON, NP and nurse managers on 10-13-11 for PT/INR monitoring, the Coumadin order, and the MAR for accuracy. On 10-26-11 residents on Coumadin were assessed for adverse effects such as signs and symptoms of bleeding and/or bruising by LPN's RN's and Unit Managers. The Unit Managers updated care plans on 10-25-11 for interventions for bleeding precautions. The ED gave the pharmacist consultant the schedule of the Quality Assurance meetings for their participation on 10-26-11. A Quality Assurance meeting was held on 10-21-11 which included the Coumadin process of monitoring PT/INRs and verifying dosage and administration, educating staff on signs and symptoms of bleeding and the immediate notification of the physician for change of residents' condition. The Coumadin process and staff education	

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F 520	Continued From page 56 QA review prior to the meeting on October 12, 2011. Interview with the Director of Nursing (DON) on October 18, 2011, at 11:00 a.m., in the Conference Room, confirmed the facility did not identify and implement a plan to train and educate staff on bleeding and bleeding precautions, or to notify the physician of a change in condition, or to monitor the blood thinner levels as ordered by the physician resulting in active bleeding in the mouth and a transfer to the hospital emergency room for evaluation for resident (#8). Continued interview confirmed only two licensed nurses were inserviced upon identification of the Coumadin transcription error involving resident #4. The DON stated, "I'm in the process of developing a Performance Improvement Plan, but it isn't fully developed or implemented." Continued interview confirmed the facility's QA Committee routinely meets the second Wednesday of each month and the failure to notify the physician of resident #8's active bleeding, and the significant medication errors with resident #9 have not been reviewed by the QA Committee. Continued interview with the DON confirmed known medication errors have occurred in the facility and have not been reviewed or addressed by the QA Committee. Further interview confirmed the Pharmacist has only attended two QA Committee Meetings since March 2011. Interview with the Administrator on October 18, 2011, at 2:00 p.m., in the Conference Room, confirmed the facility failed to obtain the PT/INR on August 20, 2011, for resident #8 on Coumadin Therapy. Continued interview confirmed the	F 520	was approved by the QA Committee. All licensed nurses were educated 10-22-11 through 10-26-11by the DON regarding the Coumadin process. The Consultant Pharmacists will now be providing quality assurance reporting to the facility for any out of range INR values reported during the quarter as well as a summary of recommendations made to reduce potential Warfarin risk.	

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F 520	Continued From page 57 facility failed to train and educate staff on bleeding precautions or interventions. Continued interview confirmed the Administrator was unaware resident #8 required administration of Vitamin K due to an elevated PT/INR and was sent to the Emergency Room for an elevated PT/INR and bleeding around the mouth on August 21, 2011. Continued interview with the Administrator confirmed the facility failed to provide the correct dose of Coumadin to resident #4 for three consecutive days. The Administrator confirmed only two licensed nurses were inserviced after resident #4 received an incorrect dose of Coumadin, and additional inservicing did not begin until the surveyor brought it to the attention of the Director of Nursing on October 10, 2011, Continued interview confirmed the Administrator was unaware of a Pharmacy policy to notify the facility for verification if a patient is naïve or "new" to Coumadin or if there is a significant increase in the dose from the previous regimen. Continued interview confirmed the facility's Pharmacy Services Agreement would ensure a representative from the Pharmacy is available for attendance at the facility's Quality Assurance (QA) Committee Meetings, but the Pharmacy Consultant has attended only two monthly QA Meetings since March 2011. Interview by telephone with the facility's Pharmacy Consultant on October 18, 2011, at 3:02 p.m., lasted one minute and fifteen seconds, allowing enough time to introduce the surveyor to the Consultant and the surveyor began to interview the Consultant about the facility's medication errors and the Consultant's role in the facility's QA program, and the call was ended, but not by the surveyor. The surveyor immediately	F 520		

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F 520	Continued From page 58 called the Consultant back and after numerous rings, the call went to the Consultant's voicemail and a message was left explaining the surveyor's position and the need to interview the Consultant regarding the provision of consultative services. The Consultant Pharmacist never returned the surveyor's call as requested. Interview by telephone with the Clinical Director of Pharmacy Services (and Supervisor of the facility's Consultant Pharmacist) on October 18, 2011, at 3:30 p.m., confirmed the Pharmacy's Service Agreement with the facility, provided to the surveyor by the Administrator, revealed "...RECITALS...C. The FACILITY desires to utilize the PHARMACY's services, and the PHARMACY is willing to furnish such services as provided herein...AGREEMENT...In consideration of the mutual covenants contained herein and for the reliance of the parties hereto, the FACILITY and the PHARMACY agree as follows: 1. RESPONSIBILITIES OF THE PHARMACY...1.1 Services: For the benefit of the FACILITY, the PHARMACY will:...(h) Ensure that a representative from the PHARMACY is available for attendance at the FACILITY's Quality Assurance Committee...with reasonable prior notice and during regularly scheduled visits to the FACILITY..." Continued interview confirmed the Pharmacy Consultant had attended only two monthly QA Meetings since March 2011, and the Clinical Director of Pharmacy Services stated, "(Pharmacy Consultant) has three other nursing homes with QA Meetings at the same time and (Pharmacy Consultant) can't attend all three of them." Refer to F-157 (J), F-281 (D); F-309 (J) and	F 520		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445296	A. BUILDING _____ B. WING _____	C 10/18/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF EAST RIDGE	1500 FINCHER AVENUE EAST RIDGE, TN 37412

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F 520	Continued From page 59 F-333 (J)-Substandard Quality of Care; F-425 (J), F-490 (J), F-502 (D) C/O #28690	F 520		